NHS Fife Audit & Risk Committee

Wed 15 March 2023, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Alastair Grant

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Alastair Grant

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Monday 5 December 2022

Enclosed *Alastair Grant*

Item 03 - Audit & Risk Committee Minutes (unconfirmed) 20221205.pdf (6 pages)

14:00 - 14:10
10 min

4. Matters Arising / Action List

Enclosed *Alastair Grant*

Item 04 - Audit & Risk Committee Action List 20230315.pdf (1 pages)

14:10 - 14:40
30 min

5. GOVERNANCE MATTERS

5.1. Losses & Special Payments Quarter 3 Report (Oct – Dec 2022)

Enclosed *Kevin Booth*

Item 05.1 - SBAR Losses & Special Payments Quarter 3 Report.pdf (3 pages)
Item 05.1 - Appendix 1 Summary of Losses and Special Payments 011022 – 311222.pdf (1 pages)

5.2. Committee Self-Assessment Report 2022/23

Enclosed *Gillian MacIntosh*

Item 05.2 - SBAR Committee Self-Assessment Report 2022-23.pdf (10 pages)

5.3. Annual Review of Committee's Terms of Reference

Enclosed *Gillian MacIntosh*

Item 05.3 - SBAR Annual Review of Terms of Reference.pdf (2 pages)
Item 05.3 - Appendix 1 Audit & Risk Committee Terms of Reference.pdf (8 pages)

5.4. Publication of Blueprint for Good Governance, Second Edition

Enclosed *Gillian MacIntosh*

Item 05.4 - SBAR Publication of Blueprint for Good Governance, Second Edition.pdf (5 pages)
Item 05.4 - Appendix 1 - Blueprint Second Edition.pdf (63 pages)

5.5. Payroll Service Transfer to NSS Assurance Statement

Enclosed *Margo McGurk*

- Item 05.5 - SBAR Payroll Service Transfer to NSS Assurance Statement.pdf (4 pages)
- Item 05.5 - Appendix 1 NSS South East Payroll Audit and Assurance Timeline.pdf (1 pages)

14:40 - 14:55
15 min

6. RISK

6.1. Corporate Risk Register

Enclosed *Pauline Anne Cumming*

- Item 06.1 - SBAR Corporate Risk Register + Appendix 1.pdf (7 pages)
- Item 06.1 - Appendix 2 Deep Dive Review Schedule.pdf (1 pages)
- Item 06.1 - Appendix 3 NHS Fife Corporate Risk Register as at 20 February 2023.pdf (11 pages)
- Item 06.1 - Appendix 4 Assurance Principles.pdf (1 pages)

14:55 - 15:20
25 min

7. GOVERNANCE – INTERNAL AUDIT

7.1. Internal Audit Framework

Enclosed *Tony Gaskin*

- Item 07.1 - SBAR Internal Audit Framework .pdf (3 pages)
- Item 07.1 - Appendices - Internal Audit Framework.pdf (29 pages)

7.2. Internal Audit Progress Report

Enclosed *Barry Hudson*

- Item 07.2 - SBAR Internal Audit Progress Report .pdf (3 pages)
- Item 07.2 - Appendix A Internal Audit Progress Report.pdf (4 pages)

7.3. Internal Audit – Follow Up Report on Audit Recommendations 2021/22

Enclosed *Barry Hudson*

- Item 07.3 - SBAR Internal Audit – Follow Up Report on Audit Recommendations 2021-22 .pdf (19 pages)

7.4. Internal Controls Evaluation Final Report 2022/23

Enclosed *Tony Gaskin*

- Item 07.4 - SBAR Internal Controls Evaluation Report 2022-23 – Final Report.pdf (2 pages)
- Item 07.4 - Appendix A Internal Control Evaluation B0823.pdf (42 pages)

15:20 - 15:45
25 min

8. GOVERNANCE – EXTERNAL AUDIT

8.1. External Audit Plan

Enclosed *Chris Brown/Karen Jones*

- Item 08.1 - NHS Fife External Audit Plan 2022-23 - draft.pdf (49 pages)

8.2. External Audit – Follow Up Report on Audit Recommendations

Enclosed *Margo McGurk*

- Item 08.2 - SBAR External Audit – Follow Up Report on Audit Recommendations.pdf (7 pages)

8.3. External Audit Plan – Patients Private Funds

Enclosed *A Mitchell, Thomson Cooper*

Item 08.3 - External Audit Plan – Patients Private Funds.pdf (25 pages)

15:45 - 15:55
10 min

9. FOR ASSURANCE

9.1. Audit Scotland Technical Bulletin 2022/4

Enclosed *Kevin Booth*

Item 09.1 - SBAR Audit Scotland Technical Bulletin 2022-4.pdf (3 pages)
Item 09.1 - Appendix 1 Audit Scotland Technical Bulletin 2022-4.pdf (36 pages)

9.2. Audit Scotland Annual Overview Report 2022

Enclosed *Margo McGurk*

Item 09.2 - Audit Scotland Annual Overview Report 2022.pdf (56 pages)

9.3. Delivery of Annual Workplan 2022/23

Enclosed *Margo McGurk*

Item 09.3 - Delivery of Annual Workplan 2022-23.pdf (6 pages)

9.4. Annual Audit & Risk Committee Workplan 2023/24

Enclosed *Margo McGurk*

Item 09.4 - SBAR Annual Audit & Risk Committee Workplan 2023-24.pdf (2 pages)
Item 09.4 - Appendix 1 Annual Audit & Risk Committee Workplan 2023-24.pdf (4 pages)

15:55 - 16:00
5 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

10.1. To the Board in the IPQR Summary

Verbal *Alastair Grant*

10.2. Chair’s comments on the Minutes / Any other matters for escalation to NHS Fife Board

Verbal *Alastair Grant*

16:00 - 16:00
0 min

11. ANY OTHER BUSINESS

16:00 - 16:00
0 min

12. DATE OF NEXT MEETING - 18 MAY 2023 AT 2PM VIA MS TEAMS

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON MONDAY 5 DECEMBER 2022 AT 2PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Cllr David Graham, Non-Executive Member
Anne Haston, Non-Executive Member
Aileen Lawrie, Non-Executive Member
Kirstie MacDonald, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Pauline Cumming, Risk Manager
Tony Gaskin, Chief Internal Auditor
Barry Hudson, Regional Audit Manager
Karen Jones, Azets
Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting. A warm welcome was extended to Anne Haston, Non-Executive Member, who became a member of the Audit & Risk Committee on 1 December 2022, and to Karen Jones, from Azets, who is attending her first meeting.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the notes are being recorded with the Echo Pen to aid production of the minutes.

1. Apologies for Absence

Apologies were received from attendees Carol Potter (Chief Executive) and Chris Brown (Azets).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 12 September 2022

The minute of the last meeting was **agreed** as an accurate record.

4. Action List / Matters Arising

The Audit & Risk Committee **noted** the updates provided and the closed items on the Action List.

5. GOVERNANCE MATTERS

5.1 Losses & Special Payments

The Head of Financial Services & Procurement provided an update on losses and special payments, noting that the position is as expected, compares favourably to the previous year, and is under target.

The Committee took **assurance** from the update.

5.2 Proposal to Increase Procurement Tender Thresholds

The Head of Financial Services & Procurement outlined the proposal and highlighted the levels that are proposed to be updated in the Financial Operating Procedures and Standing Financial Instructions.

Following a question from K MacDonald, Non-Executive Member, the Head of Financial Services explained that the minimum number of suppliers from whom quotes are obtained follows the guidance within the Procurement Reform Act.

The Audit & Risk Committee **endorsed** the amendment to the current Tender Threshold limit and **recommended** approval to the Board of the proposed update to the wording within the Standing Financial Instructions, as set out in the paper.

6. RISK

6.1 Corporate Risk Register

The Director of Finance & Strategy noted that the Corporate Risk Register was presented to the Board at the November 2022 meeting, and it was recognised that three out of four strategic priorities are operating beyond the current Board Risk Appetite threshold. It was advised that, following discussion at the Board, the Risk & Opportunities Group will be assigned a specific task to come forward with a proposal around tolerating a level of risk appetite for mitigations which are not having the impact that was expected. The Chief Internal Auditor commented that recalibrating the risk appetite could be an option for those risks that cannot meet the risk appetite.

The Director of Finance & Strategy highlighted the key role the Risk & Opportunities Group will have through the development of the Corporate Risk Register and noted that the register will be iterative throughout its development. Regular feedback from the Risk & Opportunities Group will be provided to the Audit & Risk Committee on the challenges of the risk position.

An overview of the risks aligned to the Governance Committees was provided, and it was advised Internal Audit had been supportive in the development of the new approach. It was reported that each Governance Committee, with the exception of the

Staff Governance Committee due to timing, have had a deep dive into a specific report relative to their area, to date.

K MacDonald, Non-Executive Member, questioned the visibility of a risk management report, which includes information on actions taken, intended impact, actual impact and changes that need to take place, to provide assurance to the Committee that risks are being monitored and changes considered. The Director of Finance & Strategy advised that this detail will be brought together through the deep dive process. It was agreed to take this forward with the Risk & Opportunities Group for an interim solution whilst the deep dive process progresses.

The Chief Internal Auditor highlighted the importance of alignment of Corporate Risks to Governance Committees, which will enable scrutiny on deep dives, and provide assurance to the Audit & Risk Committee.

The Board Secretary reminded the Committee that a Committee Assurance Principles Development Session is scheduled for 13 February 2022. Committee Chairs for each of the Governance Committees will be invited to join the session.

Action: Board Committee Support Officer

The Committee took **assurance** from the update.

6.2 Risk & Opportunities Group Terms of Reference and Progress Report

The Risk Manager advised that a focus for the newly formed Risk & Opportunities Group has been around establishing the role and remit of the group. The Executive Directors' Group scrutinised the Terms of Reference at their meeting on 17 November 2022 and they were then subsequently approved at the Risk & Opportunities Group on Friday 2 December 2022. Assurance was provided that the group now have clear objectives going forward.

The Risk Manager advised that the Risk & Opportunities Group have also focussed on the Corporate Risk Register, improvements on the deep dive reports, Population Health & Wellbeing Strategy, frameworks to support activity, and they have just commenced discussions on the key performance indicators.

The Committee took **assurance** from the update.

6.3 Risk Management Key Performance Indicators (KPIs) Update

The Risk Manager provided a verbal update and advised that through the Risk & Opportunities Group, a review of the KPIs is underway, which includes identifying all the various components within the current risk profile. Once this exercise has been carried out, KPIs and measures will be developed, which will be regularly reported on.

It was noted an analysis was carried out on organisational risks, as part of the KPI review, and it was identified that more than 60% of these risks sit within the Corporate Directorate, with a significant number relating to projects and programmes.

The Committee took **assurance** from the update.

7. GOVERNANCE – INTERNAL AUDIT

7.1 Internal Audit Progress Report

The Regional Audit Manager spoke to the report and noted an amendment to B13/22 and B06/22, advising that both these audit reports are in draft and the final version will be issued over the coming weeks.

The Committee took **assurance** from the progress on the delivery of the Internal Audit Plans.

7.2 Internal Audit – Follow Up Report on Audit Recommendations 2022/23

The Regional Audit Manager spoke to the paper and highlighted an increase in the number of outstanding recommendations due. Assurance was provided to the Committee that this is not, however, an area of concern and is due to the timing of producing the report. It is expected that the outstanding recommendations will either be extended or preferably completed before the next report to the Committee.

The Regional Audit Manager highlighted that the title for B16/22 should read 'Safer Use of Medicines'.

The Director of Finance & Strategy provided assurance that the Executive Directors' Group dedicated time to review the report on a quarterly basis, and it was noted it is recognised that there is still work to be carried out for some recommendations, however, there is an improvement in levels of engagement.

The Committee took **assurance** of the current status of Internal Audit recommendations recorded within the Audit Follow-Up system.

7.3 Draft Internal Control Evaluation Report 2022/23

The Chief Internal Auditor provided background information and an overview on the Internal Control Evaluation Report, which outlines a mid-year position for the Committee.

It was advised that actual and target risk scores have been increased, which reflects the changes in the external environment.

The Chief Internal Auditor reported that there is a need for strategic change with operational savings, noting that a Population Health & Wellbeing Strategy is in development and there is a Strategic Planning & Resource Allocation (SPRA) process, both of which are generating strategic change. It was noted workforce and finance are key priority areas within the plans going forward.

The Chief Internal Auditor highlighted the positive key developments, including the Operational Pressures Escalation Levels (OPEL) and risk management development.

It was reported the final report will be presented to the Governance Committees at the March 2023 cycle of meetings.

The Committee **noted** the draft Internal Control Evaluation Report 2022/23.

8. GOVERNANCE – EXTERNAL AUDIT

8.1 External Audit – Follow Up Report on Audit Recommendations

The Head of Financial Services & Procurement highlighted the key recommendations from the external audit. In terms of the Integration Joint Board adjustments, it was advised a further resource has been added to the Finance Team and it is anticipated there will not be the same challenges this year, compared to the previous year, with reconciling the balances.

In terms of the brought forward recommendations, it was reported that two Payroll Officers have been recruited. It was noted that the NHS Fife payroll service will become part of the South East Scotland Payroll Consortium as of 1 February 2023.

The Committee took **assurance** from the progress made against the 2021/22 External Audit recommendations.

8.2 External Audit Plan 2022/23 – AZETs

K Jones, from Azets, presented on the External Audit Strategy 2022/23. It was advised that a detailed audit plan will be provided to the Committee at the March 2023 meeting.

It was reported that the strategy sets out the audit approach for the coming year, which is similar to the Audit Scotland's approach. It was noted changes will take effect for 2022/23, in particular, a new Code of Audit Practice which applies to audits from 2022/23, and minor revisions to the auditing standards in terms of the timing of the audit approach. An overview on the requirements of the new Code of Audit Practice was provided. It was noted that the auditing standards will have an impact on the planning and risk procedures that are carried out.

It was advised the audit timetable will be set out; however, planning and interim procedures are continuous throughout.

The Committee took **assurance** from the update and **noted** the External Audit Plan will be presented to the Committee for review and approval at the March 2023 meeting.

9 FOR ASSURANCE

9.1 Audit Scotland Technical Bulletin 2022/3

The Head of Financial Services & Procurement advised that there is no specific section relating to health in the Quarter 3 bulletin, however he noted that Chapter 6 highlights a number of fraud and irregularities that were brought to the attention of Audit Scotland. Assurance was provided that internal controls remain sufficient and are routinely followed across NHS Fife.

The Committee took **assurance** from the Board's implementation of the Audit Scotland Technical Bulletin 2022/3.

9.2 Delivery of Annual Workplan

The Board Secretary presented the annual workplan, noting the 'FTF Shared Service Agreement/Service Specification' has been deferred to the March 2023 meeting. The Regional Audit Manager advised that this was due to the timing of the Partnership Board meetings.

The Committee took **assurance** on the delivery of the tracked workplan.

9.3 Proposed Annual Workplan 2023/24

The Board Secretary advised the annual workplan for 2023/24 is currently being considered. It was noted it is predicted the annual accounts items will take place in June 2023.

The Committee **noted** the proposed annual workplan. The Committee was advised a final version will be brought back to the Committee at the March meeting.

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

11. ANY OTHER BUSINESS

None.

Date of Next Meeting: Wednesday 15 March 2023 at 2pm via MS Teams.

KEY:	Deadline passed / urgent
	In progress / on hold
	Closed

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Wednesday 15 March 2023

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	An update will be brought back to the Committee on developments as the business case is finalised.	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update was provided at the September meeting.	In progress
2.	05/12/22	**Committee Assurance Principles**	To invite Committee Chairs for each of the Governance Committees to join the Audit & Risk Development Session.	**HT**	December 2022	13/12/22 - Complete.	Closed

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Losses and Special Payments Quarter 3**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- National policy

This aligns to the following NHS Scotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering quarter three (01/10/22 – 31/12/22).

2.2 Background

The Boards Losses and Special Payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the Annual Accounts process. As per section 16 of the Financial Operating Procedures, any potential losses or special payments are approved by the relevant Directorate/Department Head. The Loss, theft or damage paperwork is then provided to the Deputy Director of Finance for final approval.

The Losses and Special payments for the quarter are compiled into a report with a format and categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, Debtors balances written off, damage/loss of equipment and stock, Vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation

payments for any legal claims that are negotiated and settled on the Board's behalf by the Central Legal Office following consultation with the Director of Finance & Strategy.

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/10/22 – 31/12/22. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 175 Losses and Special Payments in the quarter which is comparable to the previous quarter (178). The cost in the third quarter however was an increase in comparison to the second quarter of 2022/23 (£1,369,421 compared to £773,361) and follows an increase from the Quarter 1 to Quarter 2 return. This increase was predominantly as a result of the increase in value of the clinical ex-gratia compensation payments (£1,324,181 up from £714,448) whilst the non-Clinical ex-gratia compensation payments did reduce (£36,145 down from £50,682) and have continued to fall since Quarter 1.

The Losses and Special Payments out-with the Clinical and Non-Clinical Legal settlements were slightly up in comparison to quarter 2 (£9,095 up from £8,231). The quarterly review with the Treasury Team did not return any enquiries of note.

The current position covering the first three quarters of 2022/23 (759 payments for a total of £2,923,839) remains below the full year position (826 payments for a total of £4,289,593) reported to the Scottish Government during the 2021/22 Annual Accounts process.

2.3.1 Quality/ Patient Care

The Losses and Special Payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for staff to ensure appropriate treatment is stated in the Financial Operating Procedures.

2.3.3 Financial

The Losses and Special Payments are included within the Boards Annual Accounts process, subject to external audit and submitted to the Scottish Government for oversight.

2.3.4 Risk Assessment/Management

The level of the Board's Losses and Special Payments are monitored to minimise any potential reoccurrence and future exposure to the Board.

2.3.5 Equality and Diversity, including health inequalities

The Board's treatment of its losses and special Payments is consistently applied and follows the Financial Operating Procedures where relevant to ensure equity of treatment.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly Losses and Special Payments are compiled by the Treasury Team and are presented to the Head of Financial Services and Procurement ahead of the annual submission to the Scottish Government. The losses and Special Payments included in the report have been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 31 December 2022.

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/10/22 – 31/12/22

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

FIFE HEALTH BOARD

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	OCT'22 - DEC'22		JAN'22 - DEC'22	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash			2	170
2	Stores/procurement				
3	Equipment	1	1366	3	2666
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*			15	11626
6	Buildings & Fixtures *Vandalis*	4	1144	71	8811
7	Other			3	36
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)				
8	Cash				
9	Stores/procurement				
10	Equipment				
11	Contracts				
12	Payroll				
13	Other				
14	**Nugatory & Fruitless Payments**				
	Claims Abandoned:				
15	(a) Private Accommodation				
	(b) Other *Hardship Accounts*	140	4219	556	40774
	Stores Losses:				
16	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident				
17	Deterioration in Store				
18	Stocktaking Discrepancies				
19	Other Causes				
	Losses of Furniture & Equipment				
	and Bedding & Linen in circulation:				
20	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Loss / Damaged E*	2	994	18	7400
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical				
24	Non-clinical				
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex	16	1324181	34	2640926
27	Compensation Payments - ex	5	36145	23	197126
28	Compensation Payments - ex	6	972	31	13505
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditu*	1	400	3	800
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		175	1369421	759	2923839

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Committee Self-Assessment Report 2022-23**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Discussion

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Audit & Risk Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

2.2 Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

A light-touch review of the standard question set was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the

questionnaire. Board Committee Chairs each approved the set of questions for their respective committee.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in early February 2023. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite responses for the Audit & Risk Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference, with adequate membership, an appropriate schedule of meetings and processes in place to allow for escalation of matters directly to the Board. It was also agreed that the various process in place for Audit & Risk around the scrutiny of the annual accounts were working well.

Self-Assessment questionnaire (completed by members and attendees)

In total, four members of the Committee who were in post over 2022/23 (excluding the Chair) and five regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a positive assessment from its members and attendees who participated. The recent training opportunities through dedicated briefing and development sessions have been welcomed, as has the enhanced financial skills from the Non-Executive membership.

Some areas for improvement were, however, highlighted. Initial comments identified for further discussion include:

- reviewing the volume of papers provided, enhancing the clarity of data therein and adding better signposting in the recommendations for members;
- ensuring new members receive adequate training, particularly around the more technical aspects of the Committee's work and yearly cycle of business (annual accounts etc.); and

- allowing time in the meeting cycle for a focussed review of recent governance changes, such as how the new Corporate Risk Register is bedding in (this could be scheduled as a topic for the next Development Session, for instance).

In relation to the issue of induction and allowing new members to develop appropriate knowledge of the key areas under the Committee's remit, it is suggested that in 2023/24 a specific Induction Handbook is created for each Board Committee, containing key information such as Terms of Reference, Membership, the previous year's Annual Committee Assurance Report and any further reading / links to national audit-related guidance of particular relevance to the Committee's area of responsibility. This would help address the feedback on providing more background on the skill-set of members and providing assistance with understanding audit-specific terminology. This document can be refreshed regularly, as required, and would be expected to take the form of pre-reading material for new members before they meet with the Committee Chair and Executive Lead as part of their formal introduction to their new committee.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Other impact

N/A

2.3.8 Communication, involvement, engagement and consultation

Invitation, and reminders, to complete the questionnaire were sent to all members, allowing for all the chance to submit feedback.

2.3.9 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for:

- **Discussion** – what actions members would wish to see implemented to address those areas identified for improvement.

2 List of appendices

The following appendices are included with this report:

- Appendix 1 – Outcome of Committee's self-assessment exercise

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics						
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	2 (22%)	7 (78%)	-	-	This is better now we have an accountant. I was a member for three meeting only to support gap in memberships.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	2 (22%)	6 (66.5%)	1 (11%)	-	Council representative now sorted. I think it would be worth considering a rolling membership of more clinical facing staff.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	1 (11%)	8 (89%)	-	-	New members will understandably need more time to familiarise themselves and gain experience in all aspects of the committee remit.
A4.	Committee members are able to express their opinions openly and constructively.	6 (66.5%)	3 (33.5%)	-	-	-
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	1 (11%)	8 (89%)	-	-	On some occasions there does not appear to be any scrutiny or challenge on papers etc. However, that could mean the papers provide the required information etc.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	-	9 (100%)	-	-	From looking at agendas etc, I feel that briefings are provided to the members as required.
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	-	9 (100%)	-	-	As above, new members will understandably need more time to familiarise themselves and gain experience in all aspects of the committee remit.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
B. Committee meetings, support and information						
B1.	The Committee receives timely information on performance concerns as appropriate.	3 (33.5%)	6 (66.5%)	-	-	When required. However, the volume of papers is difficult to manage at times.
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	3 (33.5%)	6 (66.5%)	-	-	When required.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	1 (11%)	8 (89%)	-	-	Mostly through year-end assurances.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	3 (33.5%)	5 (55.5%)	-	1 (11%)	I would comment that sometimes I feel too much information can be provided, which, when coupled with a lengthy agenda, risks the key information being overlooked for other material. The volume of papers is excessive. The focus for meetings I attended was annual assurance reporting.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	4 (44.5%)	5 (55.5%)	-	-	However, due to the complexity and volume scrutiny is compromised.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	4 (44.5%)	5 (55.5%)	-	-	Time is not an issue, and all members are asked to contribute.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	6 (66.5%)	3 (33.5%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	6 (66.5%)	3 (33.5%)	-	-	-
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's strategies, policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	3 (33.5%)	6 (66.5%)	-	-	Annual Report is comprehensive.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub groups) is operating effectively as part of the overall governance framework.	1 (11%)	8 (89%)	-	-	-
C. The Role and Work of the Committee						
C1.	The Committee reports regularly to the Board verbally and through minutes, can escalate matters of significance directly and makes clear recommendations on areas under its remit when necessary.	5 (55.5%)	4 (44.5%)	-	-	-
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	3 (33.5%)	6 (66.5%)	-	-	-
C3.	The Committee's agenda is well managed and ensures that all topics with the Committee's overall Terms of Reference are appropriately covered	5 (55.5%)	4 (44.5%)	-	-	-
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	5 (55.5%)	4 (44.5%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	As per my earlier comment on the quantity of information provided. My concern is always that key information can be overlooked. Less volume of paperwork, perhaps more focussed "deep dive" into areas to allow better/more scrutiny. Development session time can now be re-established more regularly and should focus on areas of change in governance arrangements and impact assessment of that change. An example would be a focussed session on how the new Corporate Risk Register arrangements are progressing. Unable to comment as my input was for three meetings where focus was mainly around the annual assurance process. Enjoyed the meetings. A glossary of audit terminology I think would be really helpful in supporting members to understand reports.				
D. Audit & Risk Committee specific questions						
AR1.	To your knowledge, at least one of the Audit & Risk Committee members has sufficient relevant and recent financial experience.	4 (44.5%)	5 (55.5%)	-	-	Not sure about this, I think it would be good to have a who's who, so it is clear what member has the finance experience.
AR2.	All members, including the chair, are suitably independent of the Executive function.	4 (44.5%)	5 (55.5%)	-	-	-
AR3.	Members are sufficiently independent of the other key committees of the Board.	1 (11%)	6 (66.5%)	2 (22%)	-	Disagree – I think members are also members of other committees of the Board, I was also member of CGC.
AR4.	The Audit & Risk Committee annual schedule of meetings is suitable for NHS Fife's business and governance needs, as well as the requirements of the financial reporting calendar.	5 (55.5%)	4 (44.5%)	-	-	-
AR5.	The Audit & Risk Committee appropriately satisfies itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period.	3 (33.5%)	6 (66.5%)	-	-	-
AR6.	The Audit & Risk Committee effectively considers how accurate and meaningful the Governance Statement is.	4 (44.5%)	5 (55.5%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
AR7.	The Audit & Risk Committee appropriately considers how it should coordinate with other Committees that may have responsibility for aspects of risk management and corporate governance.	1 (11%)	7 (78%)	1 (11%)	-	I think this could be improved. There appears to be direction to "separate" information/focus that crosses/merges with other committees, I think there could be more joint committee scrutiny and conversation. Not sure on this as I only attended three meetings.
AR8.	The Audit & Risk Committee has satisfied itself that NHS Fife has adopted appropriate arrangements to counter and deal with fraud.	2 (22%)	7 (78%)	-	-	I would like to think that we can build on this understanding in the coming year through the work to achieve the Counter Fraud Standards.
AR9.	The Audit & Risk Committee has been made aware of the role of risk management in the preparation of the internal audit plan.	4 (44.5%)	4 (44.5%)	1 (11%)	-	-
AR10.	The Audit & Risk Committee's role in the consideration of the annual accounts is clearly defined.	5 (55.5%)	4 (44.5%)	-	-	-
AR11.	The Audit & Risk Committee has gained an appropriate understanding of management's procedures for preparing NHS Fife's annual accounts.	3 (33.5%)	6 (66.5%)	-	-	-
AR12.	The Audit & Risk Committee approves, annually and in detail, the internal audit plans, including consideration of whether the scope of internal audit work addresses NHS Fife's significant corporate risks.	3 (33.5%)	6 (66.5%)	-	-	-
AR13.	Outputs from follow-up audits by internal audit are appropriately monitored by the Audit & Risk Committee and the Committee considers the adequacy of implementation of recommendations.	3 (33.5%)	6 (66.5%)	-	-	-
AR14.	To your knowledge, there is appropriate co-operation between the internal and external auditors.	5 (55.5%)	4 (44.5%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
AR15.	Internal audit performance measures are appropriately monitored by the Audit & Risk Committee.	4 (44.5%)	5 (55.5%)	-	-	However, the committee members are reliant on performance measures being brought to the committee for monitoring. There may be measures that are not highlighted for scrutiny.
AR16.	The external auditors effectively present and discuss their audit plans and strategy with the Audit & Risk Committee (recognising the statutory duties of external audit).	4 (44.5%)	5 (55.5%)	-	-	-
AR17.	The Audit & Risk Committee appropriately reviews the external auditor's annual report to those charged with governance.	4 (44.5%)	5 (55.5%)	-	-	-
AR18.	The Audit & Risk Committee adequately ensures that officials are monitoring action taken to implement external audit recommendations.	2 (22%)	7 (78%)	-	-	-
AR19.	Agenda papers are circulated timely in advance of the meeting, to allow adequate preparation by Audit & Risk Committee members.	4 (44.5%)	5 (55.5%)	-	-	However, volume of papers can be unmanageable.
AR20.	Reports to the Audit & Risk Committee communicate relevant information at the right frequency, time and in a format that is effective.	4 (44.5%)	4 (44.5%)	1 (11%)	-	Reports could be more succinct, with less use of abbreviation and technical language.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Annual Review of Committee's Terms of Reference**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This report is presented to the Audit & Risk Committee for:

- Decision

This report relates to:

- Local policy

This report aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board thereafter.

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2022, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. Proposed amendments largely relate to updating the references to the risk management reporting arrangements, given the replacement of the Board Assurance Framework by the Corporate Risk Register.

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each

standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

The regular review and update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided to the Board.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for

- **Decision** – consider the attached remit, advise of any proposed changes and approve a final version for further consideration by the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Audit & Risk Committee's Terms of Reference

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 To provide the Board with the assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated April 2018.

2. COMPOSITION

2.1 The membership of the Audit and Risk Committee will be:

- Five Non-Executive or Stakeholder members of Fife NHS Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum).

2.2 The Chair of Fife NHS Board cannot be a member of the Committee.

2.3 In order to avoid any potential conflict of interest, the Chair of the Audit and Risk Committee shall not be the Chair of any other governance Committee of the Board.

2.4 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Executive Lead Officer to the Committee which Directors and other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance & Strategy (who is also Executive Lead for Risk Management)
- Chief Internal Auditor or representative
- Statutory External Auditor
- Head of Financial Services & Procurement
- Risk Manager
- Board Secretary

2.5 The Director of Finance & Strategy shall serve as the Lead Executive Officer to the Committee.

2.6 The Board shall ensure that the Committee's membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee's responsibilities for financial

reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

4.4 If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and, if relevant, the External Auditor and/or Chief Internal Auditor.

4.5 If required, the Chairperson of the Audit and Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor and the Accountable Officer.

5. REMIT

5.1 The main objective of the Audit and Risk Committee is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs. This includes:

- Helping the Accountable Officer and Fife NHS Board formulate their assurance needs, via the creation and operation of a well-designed assurance framework, with regard to risk management, governance and internal control;

- Reviewing and challenging constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board;

- Reviewing the reliability and integrity of those assurances, i.e. considering whether they are founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence;

- Drawing attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed;

- Commissioning future assurance work for areas that are not being subjected to significant review

- Seeking assurance that previously identified areas of weakness are being remedied.

The Committee has no executive authority, and is not charged with making or endorsing any decisions. The only exception to this principle is the approval of the Board's accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who, in turn, makes the decision.

5.2 The Committee will keep under review and report to Fife NHS Board on the following:

Internal Control and Corporate Governance

5.3 To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:

- control environment;
- risk management;
- information and communication;
- control procedures;
- monitoring and corrective action.

5.4 To review the system of internal financial control, which includes:

- the safeguarding of assets against unauthorised use and disposition;
- the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.

5.5 To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.

5.6 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.7 To review the disclosures included in the Governance Statement on behalf of the Board. In considering the disclosures, the Committee will review as

necessary and seek confirmation on the information provided to the Chief Executive in support of the Governance Statement including the following:

- Annual Statements of Assurance from the main Governance Committees and the conclusions of the other sub-Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation;

- Annual Statement of Assurance from the Integration Joint Board, confirming all aspects of clinical, financial and staff governance have been fulfilled, with appropriate and adequate controls and risk management in place;

- Details from the Chief Executive on the operation of the framework in place to ensure that they discharge their responsibilities as Accountable Officer as set out in the Accountable Officer Memorandum;

- Confirmation from Executive Directors that there are no known control issues nor breaches of Standing Orders/Standing Financial Instructions other than any disclosed within the Governance Statement;

- Summaries of any relevant significant reports by Healthcare Improvement Scotland (HIS) or other external review bodies.

5.8 To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

Internal Audit

5.9 To review and approve the Internal Audit Strategic and Annual Plans having assessed the appropriateness to give reasonable assurance on the whole of risk control and governance.

5.10 To monitor audit progress and review audit reports.

5.11 To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.

5.12 To consider the Chief Internal Auditor's annual report and assurance statement.

5.13 To approve the Fife Integration Joint Board Internal Audit Output Sharing Protocol.

5.14 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.15 To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and that the opportunity is given for discussions with the

Chief Internal Auditor at least once per year (scheduled within the timetable of business) and, as required, without the presence of the Executive Directors.

5.16 To review the terms of reference and appointment of the Internal Auditors and to examine any reason for the resignation of the Auditors or early termination of contract/service level agreement.

External Audit

5.16 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for the NHS Fife Annual Accounts and the NHS Fife Patients' Funds Accounts.

5.17 To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

relating to the certification of Fife NHS Board's Annual Accounts and Annual Patients' Funds Accounts.

5.19 To monitor management action taken in response to all External Audit recommendations, including Best Value and Performance Audit Reports.

5.20 To hold meetings with the Statutory Auditor at least once per year and as required, without the presence of the Executive Directors.

5.21 To review the extent of co-operation between External and Internal Audit.

5.22 To appraise annually the performance of the Statutory and External Auditors and to examine any reason for the resignation or dismissal of the External Auditors.

Risk Management

5.23 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. The Committee shall seek specific assurance that:

- There is an effective risk management system in place to identify, assess, mitigate and monitor risks at all levels of the organisation;

- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management;

- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or treat at any time), and that the executive's approach to risk management is consistent with that appetite;

- A robust and effective ~~Board Assurance Framework~~Corporate Risk Register is in place.

5.24 In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to mitigate them;

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board and enables the identification of gaps in control and assurance, so as to advise the Board;

- ~~Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required;~~

- ~~Receive and review a quarterly update on the Board Assurance Framework;~~

- ~~Assess whether the linkages between the Corporate Risk Register and the Board Assurance Framework are robust and enable the Board to identify gaps in control and assurance;~~

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk;

- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions.

- The Committee may also elect to request information on risks held on any risk registers within the organisation.

Standing Orders and Standing Financial Instructions

5.25 To review annually the Standing Orders and associated appendices of Fife NHS Board within the Code of Corporate Governance and advise the Board of any amendments required.

5.26 To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended.

Annual Accounts

5.27 To review and recommend approval of draft Fife NHS Board Annual Accounts and Patient Funds Accounts to the Board.

5.28 To review the draft Annual Report and Performance Review of Fife NHS Board within the Annual Accounts.

5.29 To review annually (and recommend Board approval of any changes in) the accounting policies of Fife NHS Board.

5.30 To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval.

Other Matters

5.31 The Committee has a duty to review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

5.32 The Committee has a duty to keep up-to-date by having mechanisms to ensure topical legal and regulatory requirements are brought to Members' attention.

5.33 The Committee shall review the arrangements for employees raising concerns, in confidence, about possible impropriety in financial management or reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

5.34 The Committee shall review regular reports on Fraud and potential Frauds as presented by the Fraud Liaison Officer (FLO).

5.35 The Chairperson of the Committee will submit an Annual Report of the work of the Committee to the Board following consideration by the Audit and Risk Committee annually.

5.36 The Chairperson of the Committee should be available at Fife NHS Board meetings to answer questions about the work of the Committee.

5.37 The Committee shall prepare and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.38 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.39 The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002.

5.40 The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Board's procedure to prevent Bribery (Bribery Act 2000).

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in doing so, is authorised to seek any information it requires from any employee or external experts.

6.2 In order to fulfil its remit, the Audit and Risk Committee may obtain whatever professional advice it requires, and may require Directors or other officers of the Board to attend meetings.

6.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external advisors with relevant experience and expertise if it considers this necessary.

6.4 The Committee's authority is included in the Board's Scheme of Delegation and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Audit and Risk Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chairperson, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 The Audit and Risk Committee will advise the Scottish Parliament Public Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**NHS Scotland 'Blueprint for Good Governance' Second Edition**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

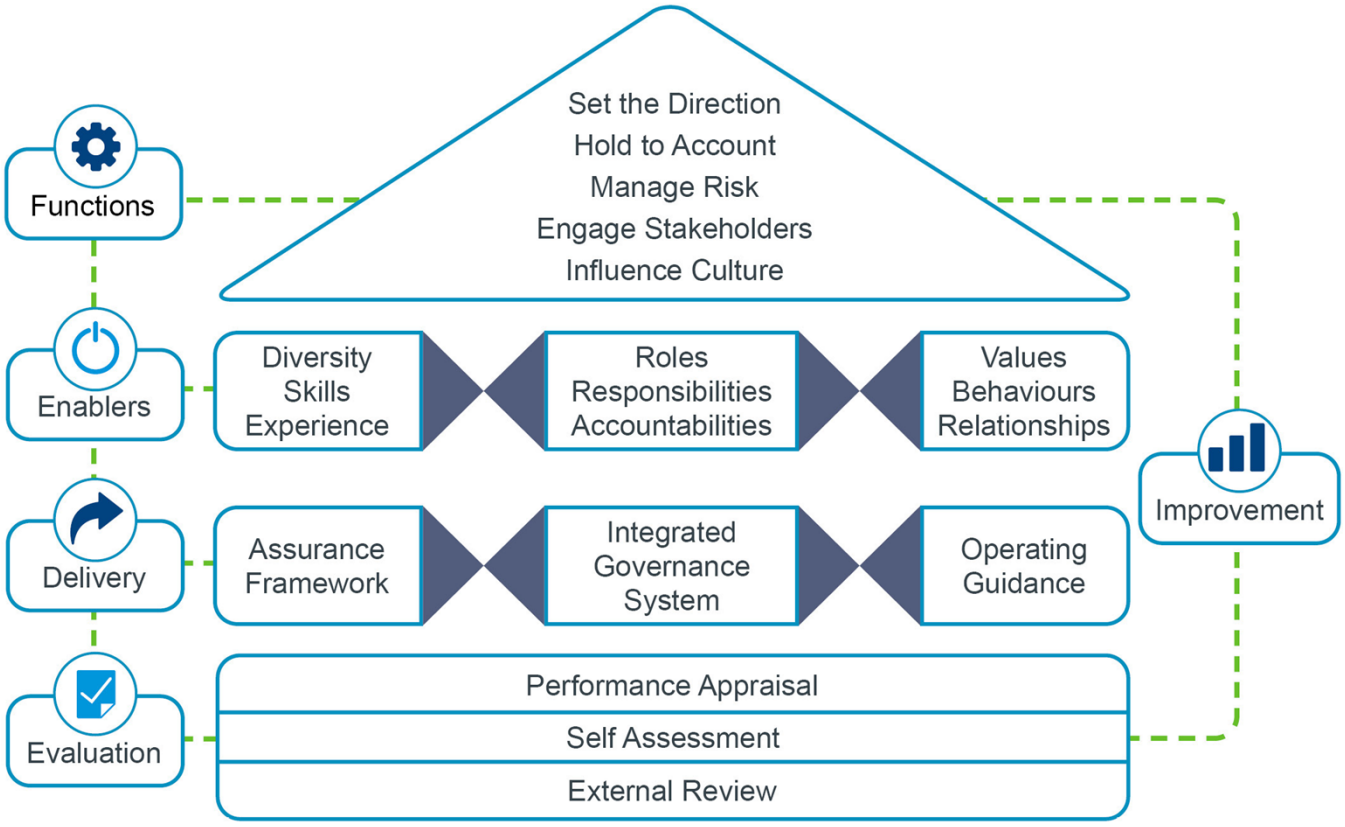
By a Director's letter issued in December 2022, all NHS Boards and Special Health Boards have been issued with the second edition of the NHS Scotland 'A Blueprint for Good Governance'. This revised edition contains guidance for best practice in corporate governance, with a particular focus on the healthcare setting, and sets out a model 'blueprint' for a system of corporate governance to be applied consistently across all NHS Boards.

Since its original issue in 2019, practical implementation of the Blueprint and its supporting suite of documents has been overseen through the NHS Scotland Chairs' sub-group, the Corporate Governance Steering Group, on which the NHS Fife Chair, Tricia Marwick, has served as a member. The NHS Scotland Board Secretaries' Group has also been leading on a number of supporting workstreams, including the creation of various 'Once for Scotland' templates to inform key governance documents, such as model Standing Orders for NHS Boards, Board and Board Committee paper templates, suggested Terms of Reference for key governance committees, and Induction programmes and material to be

used for new members. Since the Blueprint's original launch, some of this material has been issued formally by a number of Director's Letters and have thus already been adopted by NHS Fife.

2.2 Background

The NHS Scotland Blueprint defines governance as the system by which organisations are directed and controlled, describing therein a tiered model that outlines the Functions of a governance system, the Enablers and the Delivery Mechanisms required to effectively deliver those functions, and the means by which the Board can evaluate its performance in achieving the principles of good governance. Five key elements are included for Boards to demonstrate, namely: (i) Setting the Direction; (ii) Holding to Account; (iii) Managing Risk; (iv) Engaging Stakeholders; and (v) Influencing Culture. This model is illustrated as follows:



NHS Fife took steps in 2019 to deliver the original Blueprint, creating a detailed action plan of activities informed principally by Board members' completion of an online national survey and the results of a dedicated Board Development session held to discuss how the Board could adapt its processes to follow best practice and enhance its governance performance.

Updates on the delivery of the Board's earlier Blueprint action plan were reported formally to both Audit & Risk and the Board in 2021 and 2022, with the last iteration of the report closing off all outstanding actions identified from the benchmarking exercise of the Board against the previous iteration of the Blueprint.

2.3 Assessment

The revised edition of the Blueprint was issued in December 2022 and is attached as an appendix to this paper. The main changes from the previous iteration can be summarised broadly as:

- clearer definition of what 'good' looks like in relation to healthcare governance;
- recognition of the value of adopting active and collaborative approaches to governance;
- further detail on the role of advisory committees such as ACF and APF and how they are expected to support the Board and its discussions with key stakeholders;
- more detail on the delivery mechanisms to be used by Boards and the evaluation of their effectiveness;
- more emphasis on the strategic nature of the NHS Board and its members and advice on its involvement in operational matters; and
- increased emphasis on continuous improvements of governance arrangements in the NHS.

There are a number of new sections in the revised edition, including detail on Assurance Frameworks (which are wholly compatible with the Committee Assurance Principles Fife has already been working on with other Boards with in the FTF Audit Consortium); the Strategic Planning & Commissioning System; Risk Management System; and Audit Arrangements. These give useful detail to which the Board can benchmark its current arrangements against. External review of each Board's governance arrangements are expected to be introduced, on a cycle of at least every three years. No further detail is available at present, but this would be expected to support the Board's own internal appraisal and review processes that are currently undertaken annually.

In relation to implementation of the revised Blueprint, it is intended by Scottish Government that a 'Governance event' is held by summer 2023, to which Chairs and Non-Executives will be invited to participate. This has now been confirmed as taking place on Wednesday 26 April, in person in Edinburgh with also the opportunity to attend remotely. This invitation is open to all NHS Chairs, Non-Executive Board Members, Executive Board Members, Stakeholder Board Members, Board Secretaries and others involved in Governance.

Two NES training modules for the Board Development website are also currently in development, with the first expected to be available by early summer. NHS Highland is currently trialling the content of a draft survey (of c.60 individual questions) for Board members, which focuses on how well the Board is currently delivering against the content with the second edition of the Blueprint for Good Governance. It is anticipated that this will be rolled out nationally and the responses to which will then enable individual Boards to develop areas of priority to focus upon. There is no date known at present as to when the final survey will be available for use in NHS Fife.

2.3.1 Quality / Patient Care

Delivering improved governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

The implementation of any of the recommendations from this paper can be met from existing resource.

2.3.3 Financial

There are no financial implications from this work.

2.3.4 Risk Assessment / Management

Compliance with the revised Blueprint will evidence that NHS Fife has robust corporate governance practices in place that help deliver and support organisational objectives and is continually seeking to improve in this area.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

There are no specific Equality and Diversity issues arising from undertaking this work. The revised Blueprint contains further guidance on how Boards should interact with key stakeholders, including local communities, so this will be an important aspect of the forthcoming self-assessment.

2.3.6 Climate Emergency & Sustainability Impact

No impact.

2.3.7 Communication, involvement, engagement and consultation

The revised Blueprint is a product of nationally led discussions by NHS Board Chairs. Its implementation is also expected to be defined nationally.

2.3.8 Route to the Meeting

This paper has been initially reviewed EDG at its meeting on 2 March, prior to submission to the Audit & Risk Committee.

It will be reported formally to the Board in March 2023.

2.4 Recommendation

The Audit & Risk Committee is invited to:

- **Note, for assurance,** the information provided in this paper on the issuing of the second edition of the NHS Scotland Blueprint of Good Governance and the further detail still to be received on its implementation timeline.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 – Directors' Letter and NHS Scotland Blueprint for Good Governance Second Edition

Report Contact
Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

Directorate For Health Finance and Governance
Richard McCallum, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 3464
E: richard.mccallum@gov.scot

Dear Colleague

NHS SCOTLAND HEALTH BOARDS AND SPECIAL HEALTH BOARDS - BLUEPRINT FOR GOOD GOVERNANCE SECOND EDITION

1. I am writing to provide you with the second edition of the Blueprint for Good Governance. This is a revised version of the Blueprint that shares the latest thinking on healthcare governance.

Background

2. The first edition of the Blueprint for Good Governance was published in January 2019 and since then NHS Boards have been adapting this model to meet the needs of their organisation and respond to the challenges faced by the NHS, including the impact of the Coronavirus pandemic.

3. This second edition takes on lessons learnt and latest thinking on governance to define what is meant by good governance, including active and collaborative governance. It also has a greater emphasis on the delivery mechanisms that support governance and the continuous improvement approach needed to ensure governance is responsive to the challenges facing the NHS.

4. Further work is underway to ensure accurate evaluation of governance and an advisory group will be set up to ensure self assessment and external assessment methods are in line with good governance practice. This will enable Boards to enhance their governance structures and practice.

Action

5. All Boards should familiarise themselves with the second edition Blueprint.

Yours sincerely

Richard McCallum
Director of Health Finance and Governance

DL (2022) 38

22 December 2022

Addresses

For action
NHS Board Chairs

For information
NHS Board Chief Executives
NHS Board Secretaries

Enquiries to:
Corporate Business
Management Team
Area 2E(N)
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Tel: 0131 244 2083
E-mail: ocenhs@gov.scot

The Blueprint for Good Governance in NHS Scotland

Second Edition
November 2022

Foreword

In 2018 the Scottish Government recognised the need to ensure that the governance arrangements in NHS Scotland were fit for purpose and keeping pace with the changing policy and financial environment. In response to this challenge, the Director General for Health and Social Care commissioned a review of best practice in healthcare governance. The outcome of the review was a blueprint for an effective governance system that could be adopted across NHS Scotland. The first edition of the Blueprint for Good Governance was published in January 2019 and since then NHS Boards have been adapting this model to meet the needs of their organisation and respond to the challenges faced by the NHS, including the impact of the Coronavirus pandemic.

As NHS Boards look forward to recovering and renewing the health and care system it is important that good governance remains in place to stabilise service delivery while continuing to support the longer term ambitions of service design and reform as part of the Care and Wellbeing Portfolio. To assist Boards in achieving that goal, the NHS Scotland Corporate Governance Steering Group commissioned additional guidance on delivering the approach described in the original Blueprint for Good Governance. The purpose of this document is to share the latest thinking on healthcare governance by publishing a revised version of the Blueprint that will support the NHS as it moves from response to recover and renew.

This second edition of the Blueprint for Good Governance now includes a definition of what is meant by 'good', placing more emphasis on the delivery mechanisms and the need to apply a continuous improvement approach to healthcare governance arrangements. Consideration of the approach to the governance of change now features more prominently in the design of the governance arrangements. The updated guidance also highlights the need for NHS Boards to adopt both active and collaborative approaches to governance.

I would like to thank all those in the Scottish Government, NHS Scotland and the other public and private sector organisations who have contributed to the development of the revised Blueprint for Good Governance. I am particularly grateful to the members of the NHS Scotland Corporate Governance Steering Group for their insight, advice and contribution to the final version of this guide to delivering good governance in healthcare.

Professor John Brown CBE
November 2022

Contents

Supplementary Guidance

1. Introduction

1.1 The purpose of this document is to provide guidance on how to deliver and sustain good corporate governance. While this approach can be adapted and applied to other areas of the public sector, it has been customised for healthcare in Scotland.

1.2 Throughout the document the term healthcare is used in its broadest sense to mean not only the delivery of clinical interventions in response to a known healthcare need but also to cover the much wider, more proactive approach required to address population health improvement and promote health more broadly.

1.3 While the primary audience for this guide is the Board Members and Executive Leadership Teams working across NHS Scotland, it will also be of interest to the UK and Scottish Governments, local authorities, integration authorities, independent (primary care) contractors, and an extensive range of public sector organisations who all have an influence on the health of individuals and communities across Scotland.

1.4 Throughout this guide references to "NHS Boards" should be considered as including the fourteen territorial Health Boards, the six special Health Boards, Health Improvement Scotland and NHS National Services Scotland.

1.5 The guidance reflects the latest thinking and best practice in healthcare governance. It presents a Blueprint for Good Governance that describes the functions, the enablers, the assurance framework, the integrated system and the operating guidance that need to be in place to support good governance. The guidance also aims to improve the effectiveness of governance in the NHS by requiring that the Boards' governance arrangements are subject to continuous review and development.

1.6 The Blueprint provides NHS Education for Scotland and other training providers with a foundation for developing training and development products. It can also be used for providing awareness and information on healthcare governance for a wider community that includes clinicians, managers and other people with an interest in health and social care.

1.7 It is important to acknowledge the requirement that governance arrangements should reflect the needs of the organisation and the environment in which it operates, and NHS Boards should adopt a flexible approach, recognising that their governance systems must take into account the individual circumstances and the specific challenges faced by their organisation.

1.8 Therefore, while it is expected that all NHS Boards adopt the principles, underpinning models and frameworks described in this guide, these should not be seen as prescriptive and Boards are expected to be flexible and adapt them to ensure they have a governance system in place that is at all times appropriate and proportionate for their organisation. This includes introducing temporary changes to governance arrangements that may be required to provide a suitable response to emergency situations, such as those experienced during the Coronavirus pandemic.

1.9 For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at the day-to-day management of operations and the implementation of change.

1.10 Therefore, the guidance provided in this document should be considered in conjunction with the various workstreams and initiatives across NHS Scotland that are focused on managing current operations, recovering from the public health emergency created by the Coronavirus pandemic and redesigning the NHS to meet the demands of the post-pandemic world.

1.11 The guidance begins by highlighting some of the challenges faced by the NHS and '**why**' having good governance is necessary to successfully respond to those challenges. It then goes on to define '**what**' good governance means in relation to healthcare before describing the blueprint for **'how**' this can be delivered, including '**who**' is accountable and responsible for ensuring good governance across NHS Scotland.

2. The Importance of Good Governance

2.1 In common with healthcare providers across the globe, NHS Scotland finds itself operating in an increasingly demanding environment. The impact of demographic change and the growth in long term health conditions at a time of financial constraint meant that the healthcare system was already under significant pressure prior to the Coronavirus pandemic.

2.2 The need to respond effectively to the impact of the public health emergency has added even greater and unprecedented challenges for the NHS. This includes developing the role of the NHS Boards as key 'anchor institutions' in the local and national economy and finding new and innovative approaches to delivering health and social care.

2.3 If the NHS is to address the challenges it faces in improving health at population level and creating a healthcare system that meets the present and future needs of the people of Scotland, the importance of good governance should not be underestimated.

2.4 The **Independent Commission on Good Governance in Public Services**[1] emphasised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes. The Commission also highlighted that weak or ineffective governance fosters low morale and adversarial relationships that lead to poor performance or even, ultimately, to dysfunctional organisations.

2.5 Therefore, it is critical that NHS Boards ensure that robust, accountable and transparent governance arrangements are in place throughout the healthcare system.

2.6 NHS Boards need to be able to demonstrate that their governance arrangements respect and pursue the rights and interests of all their stakeholders, and enable Board Members to hold their Executive Leadership Teams to account for improving population health and addressing health inequalities, while delivering safe, effective and high quality healthcare services.

2.7 Having established why good governance is essential in addressing the challenges the NHS faces in Scotland - but before describing in detail the Blueprint for implementing that approach - it is necessary to have a shared understanding of what is meant by '**good governance**' in healthcare.

1 www.cipfa.org/policy-and-guidance/reports/good-governance-standard-for-public-services

3. The Definition of Good Governance

3.1 A description of good governance that underpins the revised Blueprint has been developed that brings together an updated definition of the '**governance**' of healthcare with a list of the underlying principles that support the delivery of '**good**' governance.

3.2 This description of what is meant by '**good governance**' is further enhanced by explanations of the terms '**active**' and '**collaborative**' in the context of good governance.

The Governance of Healthcare

3.3 The publication of the **NHS Scotland Blueprint for Good Governance**[2] in 2019 described governance as "The system by which organisations are directed and controlled". While this statement was useful in clarifying what was meant by 'governance' in general, it is less helpful when considering what is specifically required to deliver good governance in a healthcare setting in 2022 and beyond.

3.4 Therefore, a more up to date and relevant definition of governance has been developed and approved by the NHS Scotland Corporate Governance Steering Group. The following paragraphs describe the thinking behind the development of this revised definition of 'governance'.

3.5 The **UK Corporate Governance Code**[3] also defines governance as "The system by which organisations are directed and controlled". It expands on that statement by adding that "Governance is about what the board does and how it sets the values of the organisation and is to be distinguished from executive director led day-to-day operational management". This recognises that a good governance system can also help individuals avoid the tension and conflict that can arise in an organisation where the boundaries between roles are not clear.

3.6 **The World Health Organisation and the Royal College of Physicians of Edinburgh's Quality Governance Collaborative**[4] have developed a joint working definition that provides further insight into what excellence in governance means in a healthcare organisation. They describe governance as "The means by which all institutions and organisations involved in the design and delivery of healthcare translate health policy into clinical practice and management in order to improve the quality and efficiency of healthcare. It is the ability to ask the right questions and to implement the right mechanisms to ensure the organisation discharges its duties in

2 www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf
3 www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf
4 www.rcpe.ac.uk/college/QGC

line with its purpose and with focus on good clinical practice". This approach focuses on the governance of clinical practice and emphasises that good governance does not just rely on having systems in place. How well Boards use these systems is a critical factor in the delivery of good governance.

3.7 By bringing these two relevant and helpful definitions together a revised definition of governance in healthcare has been developed for use by NHS Scotland. This definition is expressed as:

> "Governance is the means by which NHS Boards direct and control the healthcare system to deliver Scottish Government policies and strategies and ensure the long term success of the organisation. It is the ability to ask questions and make decisions to improve population health and address health inequalities, while delivering safe, effective and high quality healthcare services. It is to be distinguished from executive-led operational management."

3.8 Governance arrangements in the NHS should include service delivery, change management, workforce, finance, information and asset management. These arrangements must have a clear focus on clinical and care governance, including the governance of clinical research. Particular attention should also be given to educational governance and the governance of the professional standards expected of the clinicians employed by the organisation. (Further advice on educational governance can be found on **NHS Education for Scotland's**[5] website.) All these categories of governance should be considered when NHS Boards determine their arrangements and systems for delivering good governance.

3.9 Having defined what is meant by 'governance' and what should be included in the NHS Boards' governance arrangements, it is helpful to consider next what 'good' looks like in relation to the governance of healthcare.

5 www.nes.scot.nhs.uk

The Principles of Good Governance

3.10 To reflect and describe the latest thinking and best practice in governance in the public sector, ten principles of good governance have been identified. These principles underpin the design of the Blueprint for Good Governance.

3.11 **The Principles of Good Governance can be viewed as an executive summary of what is required to deliver good governance. They are as follows:**

i. Good governance requires the Board to set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture.

ii. Good governance requires a Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships.

iii. Good governance requires that roles, responsibilities and accountabilities at Board and executive level are clearly defined and widely communicated.

iv. Good governance requires an assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.

v. Good governance requires an integrated governance system that co-ordinates and links the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight.

vi. Good governance requires operating guidance that is agreed, documented, widely- communicated and reviewed by the Board on a regular basis.

vii. Good governance requires regular evaluation of governance arrangements to ensure it is proportionate, flexible and subject to continuous improvement.

viii. Good governance requires an active approach that anticipates and responds to risks and opportunities which could have a significant impact on the delivery of corporate objectives, the Board's relationships with stakeholders and the management of the organisation's reputation.

ix. Good governance requires a collaborative approach that ensures the organisation's systems are integrated or aligned with the governance arrangements of key external stakeholders.

x. Good governance requires governance arrangements that are incorporated in the organisation's approach to the management of day-to-day operations and the implementation of change.

3.12 To assist NHS Boards in adopting the Principles of Good Governance, the following paragraphs explain what is meant by an active approach and a collaborative approach in relation to governance in healthcare.

The Active Approach

3.13 Put simply, the active approach to delivering good governance requires Board Members to focus on the right things, consider the right evidence and respond in the right way.

3.14 A more comprehensive description of the active approach to governance has been defined as:

> "Active governance exists when the appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response."

3.15 This approach should not only ensure that Boards can make timely, well-informed, evidence-based and risk-assessed decisions, it will also ensure Board Members can rapidly identify, escalate and manage issues which otherwise might not be seen or understood.

3.16 While an active approach is required to deliver good governance in healthcare, it should be recognised that the NHS is only one of a range of organisations that impacts on the health of the population. Therefore, NHS Boards must also consider how they can influence and interact with the other bodies that have an impact on the delivery of quality healthcare.

The Collaborative Approach

3.17 The NHS works closely with national and local government, integration authorities, independent (primary care) contractors, the private sector, the third sector, charities, academia, communities and citizens to deliver healthcare in a joined up, person-centred manner.

3.18 Consequently, the governance of the organisations that interact with the NHS have a direct impact on population health and the delivery of healthcare services and this must be recognised when designing the governance approach for NHS Boards.

3.19 To assist in the promotion of this approach, the following definition of what collaborative means in relation to governance has been developed:

> "Collaborative governance exists when all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect the needs of each other and work together to integrate or align their arrangements for the governance of the delivery of services and products within the healthcare environment."

3.20 While fully integrating governance can be challenging, it is critical that a collaborative approach to governance is adopted by the key players in the healthcare system to ensure that the end-to- end governance arrangements are understood and aligned in order to achieve the best outcomes for the population and ensure best value in the use of public funds.

3.21 The introduction of the Principles of Good Governance will assist in delivering this approach and the development and communication of a Blueprint for Good Governance that describes the NHS approach to governance arrangements in more detail will further enable the collaborative approach.

4. The Blueprint for Good Governance

4.1 The primary purpose of the Blueprint for Good Governance is to provide guidance on how to deliver and sustain good governance in healthcare.

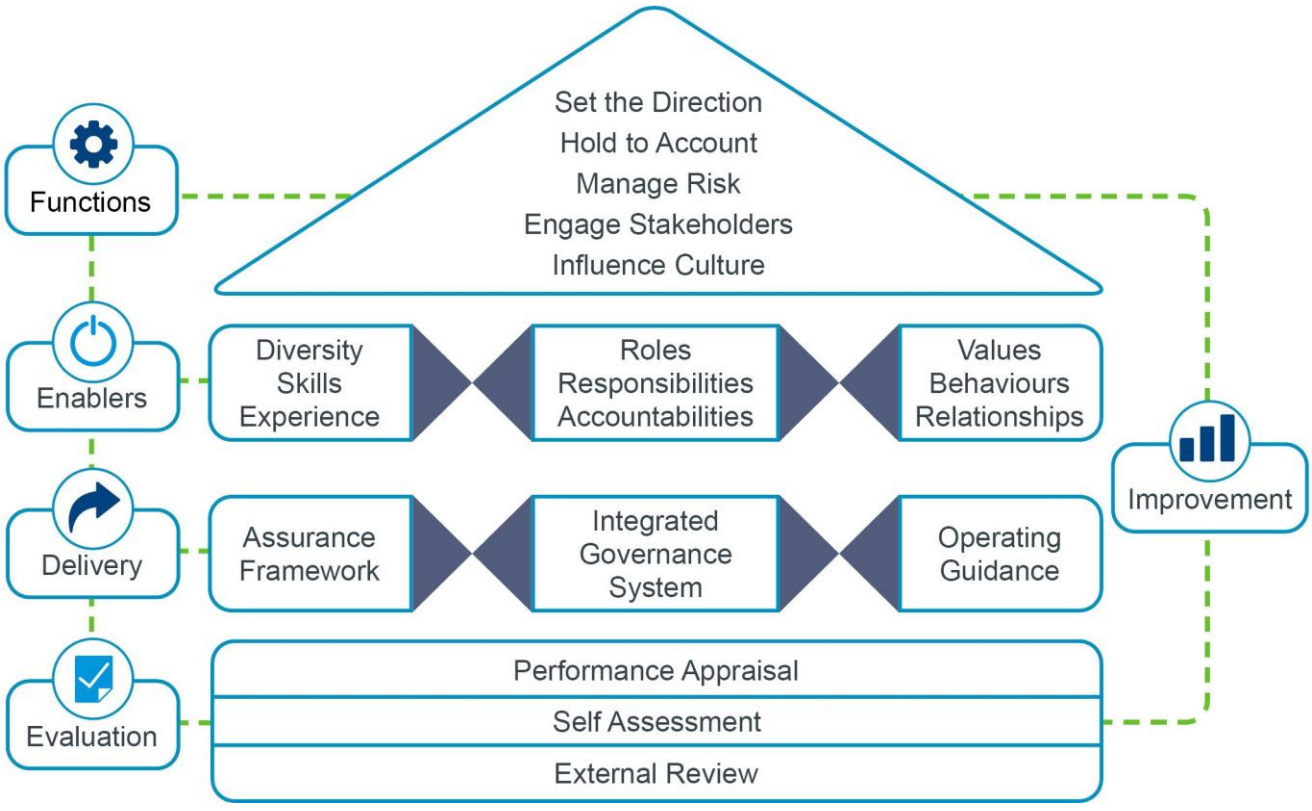
4.2 This model builds on the Principles of Good Governance that describe what good governance looks like and provides more detailed guidance to NHS Boards on the functions and the enablers of good governance. It provides definitions of the assurance framework, the integrated governance system and the operating guidance that also need to be in place to support good governance.

4.3 Adopting the Blueprint also commits NHS Boards to improving the effectiveness of governance in healthcare by requiring that Boards' governance arrangements are subject to regular evaluation and ongoing improvement activity.

4.4 The latest version of the governance Blueprint describes a four-tiered model where each component should be viewed as interdependent and subject to continuous improvement.

The Model

Figure One – The Blueprint for Good Governance



4.5 Ownership of the NHS Scotland bespoke version of the Blueprint for Good Governance rests with the Scottish Government, and accountability for reviewing and refreshing the healthcare model sits with the Director of Health Finance and Governance.

4.6 The following sections of the guide describe the component parts of the Blueprint in more detail, starting with the functions of good governance.

The Functions

4.7 **The Blueprint for Good Governance begins with a definition of the five primary functions of governance. These are described as:**

i. **Setting the direction**, including clarifying priorities and defining change and transformational expectations

ii. **Holding the Executive Leadership Team to account** by seeking assurance that the organisation is being effectively managed and change is being successfully delivered

iii. **Managing risks** to the quality, delivery and sustainability of services

iv. **Engaging with key stakeholders**, as and when appropriate

v. **Influencing** the Board's and the wider organisational culture.

4.8 The following paragraphs define the functions that need to be delivered to ensure good governance is in place.

Setting the Direction

4.9 Board Members are responsible and accountable for setting the overall strategy and direction of the organisation. They are also responsible for encouraging and facilitating innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders.

4.10 To set the direction the NHS Board should provide advice, support and guidance to the Executive Leadership Team by:

- Determining the organisation's purpose, aims, values and corporate objectives
- Approving the corporate strategic and commissioning plans required to deliver the policies and priorities of the Scottish Government
- Setting the operational priorities for the organisation and agreeing the targets for service delivery with the Scottish Government and the Executive Leadership Team
- Allocating the budgets and approving the capital investments required to deliver strategic and operational plans.

4.11 Delivering this aspect of governance is explored further in the supplementary guidance that describes the strategic planning and commissioning component of the integrated governance system.

Holding to Account

4.12 In order to hold the Executive Leadership Team to account the NHS Board requires a clear and accurate picture of current and past delivery of services. This understanding of performance over time is necessary to assist Board Members in identifying systemic change which requires further investigation and be assured that appropriate action plans are in place to address any ongoing performance issues.

4.13 To be assured about the organisation's performance, Board Members must regularly monitor performance, scrutinise results and challenge outcomes. They are required to scrutinise evidence that describes the extent to which:

- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are being delivered to an acceptable level
- Public money is being safeguarded and appropriately accounted and resources are being used to secure 'best value' as set out in the **Scottish Public Finance Manual**[6]
- The requirements of relevant regulations or regulators are being complied with to the necessary standard
- Fair and equitable systems of pay and performance management (as determined by the Scottish Government) are being applied to the reward and recognition of the workforce, including the Executive Leadership Team
- Innovation and transformational change are being delivered and benefits realised
- Continuous improvement and quality management approaches are embedded in all aspects of service delivery and system failures are identified and remediated
- Best practices are shared across the organisation with a learning culture being promoted and nurtured.

4.14 Board Members should aim to be assured rather than reassured about the organisation's performance. This requires Board Members to consider reliable sources of information before being satisfied with the pace and progress in the delivery of outcomes, rather than being advised by others that performance or actions are acceptable.

4.15 Therefore, Board Members must have easy and early access to evidence from a wide range of sources. This requires an effective flow of data, information and feedback at a frequency and in a format that enables Board Members to develop early awareness and understanding of the current situation and the risks and opportunities in the operating environment.

4.16 Delivering this aspect of governance is explored further in the supplementary guidance that describes the assurance information system component of the integrated governance system.

4.17 Effectively holding the Executive Leadership to account not only requires that Board Members have access to the relevant data in the most useful format, an active approach to governance necessitates that data is subject to the right level of scrutiny.

6 www.gov.scot/publications/scottish-public-finance-manual

4.18 To effectively challenge and prompt a worthwhile response it is important that Board Members give due consideration to the tone and manner in which they question the Executive Leadership Team. This includes recognising it is better to ask an open-ended question and to give the respondent time to answer with the appropriate level of detail and nuance.

Managing Risk

4.19 Board Members must have regard to the wider strategic and policy context in which they operate when considering the risks which could have a significant impact on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This also applies to managing the risks to the Board's relationships with key stakeholders and risks to their reputation as a public body.

4.20 Exercising vigilance and managing risk is a key component of the active approach to governance and requires Board Members to be constantly looking forward, as well as looking backwards to hold the Executive Leadership Team to account for service delivery.

4.21 Effective risk management requires that the Board should:

- Agree the organisation's risk appetite
- Approve risk management strategies and ensure they are communicated to the organisation's workforce
- Consider current and emerging risks for all categories of healthcare governance
- Oversee an effective risk management system that assesses the level of risk, identifies the mitigation required and provides assurance that risk is being effectively treated, tolerated or eliminated.

4.22 Focusing on risk will not only assist Board Members to make timely, well-informed strategic decisions that affect the long term future of the organisation, it will also ensure Boards can rapidly identify, escalate and manage issues which otherwise might not be identified or understood.

4.23 Delivering this aspect of governance is explored further in the supplementary guidance that describes the risk management component of the integrated governance system.

Engaging Stakeholders

4.24 To deliver good governance NHS Boards also need to respect and pursue the rights and interests of all the stakeholders in the healthcare system and effective stakeholder engagement is required to establish and maintain public confidence in the organisation as a public body.

4.25 There is a wide range of diverse individuals and communities who can be considered as stakeholders in the NHS. Many of these stakeholders have a keen interest and a major influence in the governance arrangements that exist in the healthcare system. These key stakeholders include:

- The people of Scotland, including their elected representative at the Scottish Parliament, the Scottish Local Authorities and the UK Parliament
- The people who receive the care provided by the NHS, including patients, service users and their families
- The people who are responsible for delivering healthcare, including the Executive Leadership Teams, the workforce employed by the NHS Boards and their Trade Unions and Professional Bodies
- The organisations who are accountable for delivering good governance, including the Scottish Government, the NHS Boards and the Integration Authorities
- The public bodies, private sector, third sector and charitable organisations that interact with and support the NHS, including delivery partners, other health and social care providers and suppliers of services to NHS Boards
- The regulatory bodies such as the Health & Safety Executive, UK and Scottish Information Commissioners, Scottish Fire & Rescue Service, and the Medicines and Healthcare Products Regulatory Agency
- The media who inform and influence public opinion by reporting and commenting on the services provided and the changes proposed to the delivery of healthcare.

4.26 To ensure meaningful engagement with their stakeholders, NHS Boards should ensure that:

- Key stakeholders are identified and the approach to engagement adopted takes into account the stakeholders' interest and influence on the work of the NHS Board
- Appropriate stakeholders are involved in the development of the Board's strategic and commissioning plans, policies and the setting of corporate objectives and operational priorities
- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are clear, well communicated and understood by all stakeholders, including patients, service users, the public, managers and staff
- The views of the relevant stakeholders are taken into account when designing services and patient pathways.

4.27 Engagement that takes place routinely helps to develop trust between communities and public bodies, fosters mutual understanding and makes it easier to identify sustainable service improvements. Effective stakeholder engagement also assists Boards to create and exploit opportunities to contribute to the Scottish Government's policies on healthcare.

4.28 The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland. **The Charter of Patient Rights and**

Responsibilities[7] summarises what people are entitled to when they use NHS services and receive NHS care in Scotland, and what they can do if they feel their rights have not been respected.

4.29 The Scottish Health Council, which operates as **Healthcare Improvement Scotland - Community Engagement**[8], has a key role in supporting NHS Boards and Integration Authorities to meaningfully engage with people and communities to shape national policies and health and social care services. NHS Boards should make use of the resources available to the Community Engagement Directorate to provide assurance that people and communities have been involved in any major service change.

4.30 Therefore, NHS Boards are required to collaborate with Community Engagement to ensure appropriate engagement with local communities throughout changes to services. This is a statutory duty that includes reviewing existing services and planning new services and patient pathways. Guidance on the planning and commissioning of health and social care services is included in the **Planning with People**[9] document published by the Scottish Government and the Convention of Scottish Local Authorities.

4.31 The criticality and potential of community planning in Scotland should be recognised by all NHS Boards. Scotland's community planning mechanisms are particularly relevant to the NHS's wider ambitions to address population health and the underlying causes of inequalities. For this reason, all Boards should take steps to seek assurance that the strongest possible contribution is consistently made to local community planning activities.

4.32 When engaging in community planning activities NHS Boards must also consider their role in promoting community empowerment. In Scotland public service reform and legislation has underpinned community empowerment. **The Community Empowerment (Scotland) Act 2015**[10] included measures which strengthened community planning and community right-to-buy arrangements, and introduced participation requests and asset transfer requests. In July 2019 Audit Scotland published a briefing on **Principles of Community Empowerment**[11]. Empowering communities remains a national priority for the Scottish Government, and all public bodies should be continually developing their systems to facilitate community empowerment. Therefore, NHS Boards should consider how their systems of governance enable and provide assurance on the effectiveness of their approach to community empowerment.

4.33 Delivering this aspect of governance is explored further in the supplementary guidance on strategic planning and commissioning.

7 **https://www.gov.scot/publications/charter-patient-rights-responsibilities-2/documents/**
8 **www.hisengage.scot**
9 **www.gov.scot/publications/planning-people**
10 **www.legislation.gov.uk/asp/2015/6/contents/enacted**
11 **www.audit-scotland.gov.uk/publications/principles-for-community-empowerment**

Influencing Culture

4.34 An organisation's culture comprises its shared values, norms, beliefs, emotions and assumptions about "**how things are and should be done around here**". These 'things' include how decisions are made, how people interact and how work is carried out.

4.35 NHS Boards have a critical role in shaping and influencing organisational culture in healthcare settings. To do this the Board should determine and promote shared values that underpin policy and behaviours throughout the organisation. Board Members must demonstrate the organisation's values and exemplify good governance through their individual behaviours.

4.36 **To ensure the delivery of the organisation's values the Board should encourage and support an organisational culture that reflects the NHS Scotland Staff Governance Standard[12]. These apply to all staff employed by NHS Boards and the Standard requires NHS Boards to demonstrate that staff are:**

i. Well informed
ii. Appropriately trained and developed
iii. Involved in decisions
iv. Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
v. Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

4.37 **The Staff Governance Standard also requires all NHS staff to:**

i. Keep themselves up to date with developments relevant to their job within the organisation
ii. Commit to continuous personal and professional development
iii. Adhere to the standards set by their regulatory bodies
iv. Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation
v. Treat all staff and patients with dignity and respect while valuing diversity
vi. Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

4.38 The Staff Governance Standard should influence and feature in the design and application of all policies and procedures for the management of people by NHS Boards. The ethos of the Staff Governance Standard should also be reflected in the arrangements with private and independent contractors and partner agencies working with the NHS.

12 www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

4.39 Boards must also ensure that the organisation successfully adopts all policies and other best practice in human resource management that is require by the Scottish Government. This includes initiatives such as the **iMatter**[13] staff experience continuous improvement tool and the **National Whistleblowing Standards**[14].

4.40 The Scottish Public Services Ombudsman has taken up the role of the Independent National Whistleblowing Officer. The aim of the role is to make sure everyone delivering NHS services in Scotland is able to speak out to raise concerns, ultimately contributing to ensuring that the NHS in Scotland is as well run as possible. The Independent National Whistleblowing Officer is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland.

4.41 To support the delivery of this organisational culture, the leadership of the organisation has to be seen as competent and credible, act in the best interest of stakeholders, act at all times with integrity and are reliable in their decisions and actions, in other words they are trustworthy.

4.42 **Therefore the Board must play its part in creating this outcome by recruiting a Chief Executive and Executive Leadership Team who have the ability, ambition, insight and values to deliver a leadership approach that delivers the Staff Governance Standard. This includes ensuring that:**

i. Leaders at all levels are sufficiently visible and give a clear sense of purpose and ambition for the organisation
ii. Leaders help people understand how they contribute to achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets
iii. Leaders set standards, recognise good performance and deal with poor performance when it arises
iv. Leaders encourage people to challenge and look for ways to improve performance and the quality of the services provided
v. Leaders help people identify and make best use of development and career opportunities.

4.43 Having this organisational culture will ensure that NHS Scotland is widely recognised as a great place to work and will generate high level of employee engagement. This will ensure the workforce is focussed on delivering high quality services that are subject to continuous improvement and quality management.

4.44 The next section of the guide considers the enablers to the successful delivery of the functions of good governance.

13 www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter
14 www.inwo.spso.org.uk/national-whistleblowing-standards

The Enablers

4.45 **To facilitate the delivery of the five governance functions, the Blueprint defines the three key enablers for good governance as:**

i. **Acquiring and retaining the necessary diversity, skills and experience** at Board level

ii. **Defining clear roles, responsibilities and accountabilities** for the principal groups and individuals that participate in the governance of healthcare

iii. **Creating relationships** and conducting business in line with agreed values and standards of behaviour.

4.46 The following paragraphs describe each of the enablers in more detail.

Diversity, Skills and Experience

4.47 The Blueprint for Good Governance highlights the importance of diversity and a range of skills and experience at Board level.

4.48 It is the responsibility of the Scottish Government, working with the NHS Board Chair, to ensure the necessary diversity, skills and experience are present across the Board. This includes determining the Board's requirements during the recruitment of new Members and the on-going development of the skills of existing Board Members.

4.49 The recruitment and appointment process is managed by the **Scottish Government Public Appointment Team**[15] who oversee the regulated public appointments process for Ministers.

4.50 The Public Appointments Team follow the Ethical Standards Commissioner's **Code of Practice for Ministerial Appointments to Public Bodies in Scotland**[16]. The Ethical Standards Commissioner and staff have a remit to encourage fairness, good conduct and transparency in public life in Scotland. The Commissioner regulates and monitors the system used to appoint Board Members and their staff play a key role in assuring that appointments are made on merit, using methods that are fair and open and reflect the diversity of Scottish society.

Diversity

4.51 Diversity is a core value at the heart of the day-to-day business of NHS Scotland. NHS Boards are required to hold their organisation to account for the inclusion and diversity strategies that must form part of their staff governance strategy. It is imperative that Boards demonstrate leadership and engagement to support anti-racist work across their organisation, ensuring improvements to equality, diversity and inclusion are continually monitored and challenged.

15 www.gov.scot/collections/public-appointments
16 www.ethicalstandards.org.uk/publication/revised-code-practice-ministerial-appointments-public-bodies-scotland

4.52 To ensure the Board reflects the diversity of their community NHS Boards should support the appointment process by implementing an appropriate attraction strategy which enables the recruitment of a diverse group of Board Members with the skills and experience required to deliver good governance. This includes taking targeted action where appropriate, encouraging and supporting applications from people with protected characteristics that are underrepresented on the Boards of Public Bodies.

4.53 **The Equality Act 2010**[17] defines protected characteristics and the recruitment process must also take into account the **Gender Representation on Public Boards (Scotland) Act 2018**[18] which describes the gender representation objective for a public board as having 50% of non-executive members who are women.

4.54 In addition to reflecting the diversity of the communities they serve, Boards require diversity of thought not only to improve decision-making but also to avoid 'group think', enabling alternative views to be debated and evaluated. If a diverse Board can demonstrate the benefits that come from its expanded knowledge, experience and insight, this should ultimately lead to an improved organisational culture and increased public confidence and trust in the NHS.

4.55 Therefore, whilst it is important to recognise that Board Members are not appointed to represent any particular body or group, there is a clear and welcomed ambition in NHS Scotland to recruit a broad and diverse representation of the population on NHS Boards.

Skills

4.56 NHS Boards require a minimum core set of skills and experience in order to discharge their responsibilities. However, while collectively NHS Boards require certain skills and experience, not every member of the NHS Board will require every skill or experience and Members will bring different levels of skill to the Board.

4.57 The recruitment, training and development of Board Members needs to be focused and built around the skills and experience they require to make an effective contribution to the governance of the organisation.

4.58 In addition to acquiring insight into the organisation and an awareness of its operating environment, Board Members need to be able to deploy a variety of skills that include:

- The capacity to question, challenge constructively and influence decision making
- The capability to recognise, listen to and respect different perspectives
- The ability to analyse and review complex issues, weighing up conflicting opinions and making timely, evidence-based, well-informed and risk-assessed decisions
- The interpersonal skills to communicate and engage with a wide range of organisations and individuals, building relationships, influencing and working collaboratively

17 www.legislation.gov.uk/ukpga/2010/15/contents
18 www.legislation.gov.uk/asp/2018/4/contents

- The confidence and self-awareness to chair, or participate as a member of, key committees that support good governance.

4.59 This definition of the skills required by NHS Boards assists NHS Education for Scotland to develop the induction training, targeted education and development activities required by Boards Members.

Experience

4.60 Board Members also bring a wide range of specialist experience and knowledge to the Board from the public, private, third or voluntary sectors. This can include lived experience of the services provided by the NHS as either a service user or provider. Experience gained in other settings or organisations can equally be of value to the delivery of good governance.

4.61 In addition to any previous experience in a governance role, the list of experience that Board Members can use to support the work of the Board is extensive and can include strategic planning, change management and operations management. Experience and training in financial management and risk management are also relevant to the governance of the NHS, as is human resource management and stakeholder management.

4.62 Board Members' experience also adds to the collective knowledge and understanding at Board level, and this is particularly welcomed around equality, diversity and inclusion, research and innovation, digital and information technology, media and communications, governance and legal issues.

4.63 Consideration should also be given to the extent to which clinicians are represented on the NHS Board. It is critical that Boards have appropriate skills and experience of clinical matters in order to be assured of the safety and quality of healthcare being delivered in both primary and secondary care settings. Having non-executive Board Members from a clinical background can assist in achieving that goal.

4.64 Given the integration of health and social care services in Scotland and the need for collaborative governance, it is also important that some experience of social care is available at Board level in the NHS.

4.65 To support succession planning and the deployment of Board Members to standing committees and other roles NHS Boards should maintain a record of the diversity, skills and experience present in the current Board. Any gaps in the diversity, skills, and experience of the Board should be reflected in the Board's succession planning, highlighted to the Cabinet Secretary when recruiting new Board Members and inform the promotion and advertising of vacancies. Boards may choose to have a Succession Planning Committee to oversee and support this activity.

4.66 The next section of the guide provides more information on '**who**' is responsible and accountable for ensuring good governance by describing the various roles, involved in the governance arrangements for NHS Scotland.

Roles, Responsibilities and Accountabilities

4.67 To support and deliver the functions described in the Blueprint for Good Governance it is essential that there is a common understanding of the roles, responsibilities and accountabilities of the principal groups and individuals that participate in the governance of healthcare.

4.68 Therefore the definitions of roles, responsibilities and accountabilities included in the Blueprint are intended to help the Scottish Government, the NHS Board Members, the Executive Directors and the Board Secretaries identify and deliver their respective functions within healthcare governance.

4.69 Together with the descriptions of the values and standard of behaviours expected of Board members, the definitions of their roles facilitates the performance appraisal of Board Members.

Scottish Government

4.70 The Scottish Parliament is responsible for the legislation that governs the delivery of healthcare in Scotland. The Cabinet Secretary for Health and Social Care has ministerial responsibility in the Scottish Government for the NHS in Scotland.

4.71 The **National Health Service (Scotland) Act 1978**[19] places a duty on the Cabinet Secretary to promote a comprehensive and integrated health service, designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness. The Cabinet Secretary may do anything which they consider is likely to assist in discharging that duty.

4.72 The Scottish Government Directorates for Health and Social Care have responsibility for health policy, the administration of the NHS, social care and public health. This includes setting the standards for governance in NHS Scotland and monitoring the adequacy and effectiveness of the governance arrangements throughout health and social care.

4.73 The Director General for Health and Social Care (who is also the Chief Executive of the NHS) leads the Directorates. With regard to the **Public Finance and Accountability (Scotland) Act 2000**[20] and the **Scottish Public Finance Manual**[21], the Director General is the designated Portfolio Accountable Officer for the Health and Social Care Directorates.

4.74 The Director of Health Finance and Governance has the responsibility for the oversight, development and support of governance arrangements across NHS Scotland and has approved the guidance contained in this document.

19 www.legislation.gov.uk/ukpga/1978/29/contents
20 www.legislation.gov.uk/asp/2000/1/contents
21 www.legislation.gov.uk/asp/2000/1/contents

4.75 The Scottish Government Directorates for Health and Social Care are responsible for various activities within the overall system of governance for health and social care. This includes:

- Developing and implementing law which determines the shape of the public sector and defines the responsibilities and duties of the Scottish Government, public bodies and others for health and social care
- Developing and implementing national strategies and policies and providing support and information to maximise the likelihood of achieving whole-system success
- Recruiting, selecting, appointing and setting the level of remuneration for all members of NHS Boards
- Appointing individuals as Accountable Officers for their organisation (normally the Chief Executive) under the **Public Finance and Accountability (Scotland) Act 2000**[22]
- Developing and implementing a Code of Conduct for Board Members under the **Ethical Standard in Public Life etc. (Scotland) Act 2000**[23] and approving the Code which each body uses
- Developing and promoting good governance practice throughout the system of health and social care. This includes working with NHS Education for Scotland and others to develop and share good practice and provide support and advice on governance matters
- Developing and implementing the performance management framework for health and social care. This involves monitoring and overseeing the performance of public bodies which report directly to the Scottish Government and putting in place a framework of support to those bodies when required to improve and sustainably deliver the required outcomes
- Discharging the Scottish Government's responsibilities as set out in the **Scottish Public Finance Manual**[24]. This includes putting a framework document in place with each public body which sets out its sponsorship relationship with the body and its Accountable Officer.

NHS Boards

4.76 The NHS Boards are legal entities established by the **National Health Service (Scotland) Act 1978**[25] and are required by this legislation to promote the improvement of the physical and mental health and the prevention, diagnosis and treatment of illness of the people of Scotland. To ensure the delivery of this NHS Boards are delegated responsibilities by the Cabinet Secretary to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the populations they serve.

22 www.legislation.gov.uk/asp/2000/1/contents
23 www.legislation.gov.uk/asp/2000/7/contents
24 www.gov.scot/publications/scottish-public-finance-manual
25 www.legislation.gov.uk/ukpga/1978/29/contents

4.77 To discharge their responsibilities under the 1978 Act, and deliver the Scottish Government policies and strategies for the provision of healthcare, NHS Boards must deliver the functions described in the Blueprint for Good Governance to the standards set by the Scottish Government.

4.78 Therefore, NHS Boards are primarily responsible and accountable for setting strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders and influencing organisational culture.

4.79 NHS Boards are also held to account by the Scottish Government for:

- Encouraging innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders
- Adopting an active approach to governance that anticipates and identifies the risks and opportunities facing the organisation, escalating significant issues to the Scottish Government when and where appropriate
- Encouraging a collaborative approach to governance by the key stakeholders in the healthcare system.

4.80 NHS Boards are also expected to actively seek and create opportunities to inform and contribute to the development of Scottish Government policies and strategies for healthcare in Scotland.

4.81 In recognition of the whole-system nature of Scotland's population health challenges, Public Health Scotland is jointly sponsored and has dual accountability lines to both the Scottish Government and to local government via the Convention of Scottish Local Authorities. This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning and performance management in relation to the work of Public Health Scotland.

4.82 It is important that the Board clearly differentiates its role from that of the Executive Leadership Team. The Chief Executive and Senior Leadership Team should be protected from individual Board Members becoming involved in operational matters. This separation of governance from day-to-day operational management is explored further in the section of the guide on the role, responsibilities and accountabilities of Board Members.

Standing Committees

4.83 To support the work of the NHS Boards a framework of appropriate standing committees should be put in place to support the delivery of good governance.

4.84 Standing committees are established on a permanent basis. They are responsible for the scrutiny of functions, services and matters delegated to them by the NHS Board, making decisions, recommendations and escalating issues to the Board, as appropriate. The standing committees make a significant contribution to the monitoring and evaluation of the progress towards achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets by providing the time, space and expertise to effectively scrutinise performance across the healthcare system.

4.85 The Board's framework of standing committees must include an Audit and Risk Committee, a Remuneration Committee and a Staff Governance Committee. The territorial Boards and some special Boards are also required to have a Clinical Governance Committee and a Research Ethics Committee. To provide the necessary governance around the regulatory framework for the award of licences for new pharmaceutical premises, territorial Boards must also have a Pharmacy Practices Committee.

4.86 In addition to these mandatory committees Boards may decide to set up additional standing committees to oversee other aspects of the organisation's operations, e.g. Acute Services, Finance and Performance and Population Health and Wellbeing Committees.

4.87 Membership of the standing committees can include non-executive and executive Board Members but the committee must be chaired by a non-executive and have a majority of non- executive members.

4.88 The agenda for the standing committees should be agreed by the committee chair and the lead executive for the committee. The agenda should include standing items to facilitate the work of the committee, including minutes and action logs, regular items as set out in the committee's Annual Cycle of business, e.g., performance and financial reports, risk registers and ad-hoc items that require attention by Board Members.

4.89 Items should be referred to a standing committee if they require input on an issue or risk that has been delegated to that committee. The standing committee members should be encouraged to add value by providing a different perspective on the issues, risks or opportunities faced by the organisation.

4.90 In addition to submitting minutes of their meetings to the NHS Board, the standing committee chairs should highlight to the Board any areas of concern or risks that require escalation to the Board for their further consideration or decision. Standing committees should also provide an annual report of their activity to the Board.

Advisory Committees

4.91 In addition to the standing committees, NHS Boards can also be supported by advisory committees to ensure that Board Members are well-informed on the issues, risks and opportunities facing the organisation.

4.92 To ensure that the views of the workforce are properly and fully considered by the NHS Board, an Area Partnership Forum must be put in place to inform and influence the Board and the Executive Leadership Team's thinking and decision-making on issues affecting the workforce. Membership of the Area Partnership Forum should include representatives of recognised Trade Unions and managers that represent the range of services provided by the organisation.

4.93 In order to harness the knowledge, skills and commitment of the clinical community across NHS Scotland and ensure that appropriate professional advice is available to NHS Boards and encourage clinicians to contribute to the planning and delivery of services, the territorial Boards must also have in place an Area Clinical Forum.

4.94 The Area Clinical Forum should be supported by a range of clinical professional advisory committees, i.e. an area medical committee, dental committee, nursing and midwifery committee, pharmaceutical committee and optical committee. The special Health Boards, Health Improvement Scotland and NHS National Services should develop appropriate arrangements for clinical engagement in accordance with the circumstances of their organisation.

4.95 To provide the NHS Board with advice on issues affecting clinical practice and employee relations the role of the advisory committees should include:

- Engaging with the Executive Leadership Team to provide insight, support and advice on the delivery of services and the implementation of change
- Supporting and advising the NHS Board in their governance of the organisation, including advice on the impact of any proposed changes that effect the employment of staff
- Identifying opportunities for the improvement of services and the wellbeing of the workforce.

4.96 Advisory committees, including the Area Partnership Forum and the Area Clinical Forum, can also play an important role in supporting the NHS Board in discussions with key stakeholders.

4.97 NHS Boards may also decide to set up additional advisory committees to focus on other aspects of the Board's business, such as equality, diversity and inclusion, or climate change and sustainability, where these issues are not already included in the remit of existing standing committees.

Networks

4.98 The NHS makes extensive use of networking to support the delivery and continuous improvement of services and the introduction of innovation and new ways of working. These also help to improve the flow of information across the NHS and establish closer working relationships between key members of the organisation.

4.99 The same approach is applied to the governance of healthcare and in addition to the Board standing committees and the advisory committees, the governance system in NHS Scotland is supported by a range of informal networks.

4.100 These networks provide regular opportunities for the leadership of the NHS to meet informally and consider any issues or risks that may be of concern, including those still to surface through the existing reporting systems. This is a valuable addition to the delivery of good governance through the formal governance arrangements.

4.101 Although the networks are separate from the decision-making bodies and the formal governance system, the benefits of networking to provide peer support, work collaboratively, share best practice, influence stakeholders and improve engagement and communications across the healthcare system is recognised, encouraged and supported by the Scottish Government.

4.102 Within NHS Scotland there are a number of such governance networks, notably the NHS Board Chairs Group and the NHS Chief Executives Group. A Vice Chairs Group, a Whistleblowing Champions Network and an Audit and Risk Committee Chairs Network have also been set up to support healthcare governance across Scotland.

4.103 A similar arrangement has been put in place for the Integration Joint Board Chairs and Vice Chairs. Introducing this network has provided an opportunity to brief and support the Integration Joint Board Members and encourage and facilitate collaborative leadership and the sharing of best practice across the Health and Social Care Partnerships. This has created another space where NHS Board Members can consider the wider context in which we operate and identify cross- system risks to the successful delivery of our services.

4.104 To promote the benefits of networking and improve the wider understanding of the purpose and remit of the networks, it is important that they publish their terms of reference. This helps communicate the work of the network and encourage other stakeholders to engage with them.

Board Chairs

4.105 The Chair of the NHS Board is responsible for:

- Leadership of the Board, ensuring that it effectively delivers its functions in accordance with the organisation's governance arrangements
- Keeping the organisation's governance arrangements and the Board's effectiveness under review
- Setting the agenda, format and tone of Board activities to promote effective decision making and constructive debate
- In the absence of a Succession Planning Committee, nominating Board Members to standing committees, Integration Joint Boards and other roles within the NHS Board and partner organisations. The allocation of roles to Board Members, including the Chair of standing committees, should be formally approved by the full Board
- Developing the capability and capacity of the Board by contributing to the appointment of Board Members; appraisal and reporting on their performance; identifying appropriate training and development opportunities; and ensuring effective succession planning is in place
- Providing performance management and identifying development opportunities for the Chief Executive
- Representing the organisation in discussions with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities and other key stakeholders. This is a responsibility shared with the Chief Executive.

4.106 The Chair is appointed by the Cabinet Secretary following a recruitment exercise undertaken by the Scottish Government Public Appointments Team.

4.107 This description of the role of the Board Chair should be seen as indicative of the role and responsibilities of the Chairs of the standing committees.

Board Vice Chairs

4.108 In addition to that of a NHS Board Member, the role of the Vice Chair includes:

- Deputising for the Chair as required in any of their duties, including representing the NHS Board in engaging with internal and external stakeholders
- Taking the lead on specific areas of the work on behalf of the Board Chair e.g. governance projects or reviews
- Providing advice, support and assistance to the Board Chair in carrying out their responsibilities
- Acting as a 'sounding board' and 'critical friend' to the Chair and the other Board Members.

4.109 The Vice Chair also provides an alternative route for Board Members to raise issues or concerns if they feel unable to do so with the Chair. This is an important part of the checks and balances within governance and accountability. If mediation by the Vice Chair does not resolve the situation, the issue or concern should be escalated to the Scottish Government.

4.110 Following an open selection process and confirmation of their suitability by the Cabinet Secretary, the appointment of the Vice Chair is made by the Board from the publicly appointed Board Members. The Board's Whistleblowing Champion and Board Members who are also employees of the organisation are excluded from this arrangement.

Board Members

4.111 All NHS Board Members are appointed by the Cabinet Secretary for Health and Social Care and the Cabinet Secretary has the authority to terminate their appointment if it is consider not in the interest of the health service that a member of a Board hold continue to hold that office.

4.112 The Board membership consists of non-executive and executive members. There are two broad categories of non-executive Board members: those appointed through the public appointment process after an open recruitment exercise, and those whom the Board's principal stakeholders have nominated for appointment by the Cabinet Secretary.

4.113 The stakeholder members are the Employee Director and, for territorial Boards, the Chair of the Area Clinical Forum and a representative from each of the Local Authorities in the area covered by the NHS Board.

4.114 NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside also have a stakeholder member to represent the medical school of the Universities of Aberdeen, Glasgow, Edinburgh and Dundee. This reflects the contribution these Boards make to NHS Scotland as the principal teaching Boards in Scotland.

4.115 The executive members for territorial Boards are the Chief Executive, Director of Finance, Nurse Director, Medical Director, and the Director of Public Health. For the special Boards, Health Improvement Scotland and NHS National Services for Scotland the executive membership of the Board can vary to meet their particular circumstances.

4.116 Publicly appointed members can serve a maximum of eight years on the Board. This limitation also applies to the appointment of the Chair and Vice Chair. Stakeholder members are also appointed for specific time periods but can be re-appointed provided the stakeholder body continues to nominate them. Executive members are appointed for the duration of their role.

4.117 NHS Board Members are responsible for:

- Ensuring the Board focuses on developing and maintaining a strategic direction designed to deliver the Scottish Government's policies and priorities
- Providing effective scrutiny, challenge, support and advice to the Executive Leadership Team on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets
- Contributing to the identification and management of strategic and operational risks
- Bringing independence, external perspectives and impartial judgement to the business of the NHS Board to support timely, well-informed, evidence-based and risk-assessed decision making at Board level
- Upholding the highest standards of integrity and probity and acting in accordance with the principle of collective and corporate responsibility for Board decisions
- Understanding and promoting diversity, equality and inclusion
- Engaging with stakeholders, including patients, service users, the public, managers and staff
- Undertaking ongoing personal development activities.

4.118 Irrespective of the basis of their appointment, their letter of appointment from the Cabinet Secretary advises that, "No Member of the Board is appointed on a representative basis for any body or group."

4.119 While Board members must be ready to offer constructive challenge, they must also share collective responsibility for decisions taken by the Board as a whole. If they fundamentally disagree with the decision taken by the Board, they have the option of recording their concerns in the minutes. However, ultimately, they must either accept and support the collective decision of the Board – or resign. Board decisions should always comply with statute, Ministerial directions (where this is provided for in statute), Ministerial guidance and the objectives of the Scottish Government's Health & Social Care Directorates.[26]

26 On Board: a guide for members of statutory boards - gov.scot **(www.gov.scot)**

4.120 To help them discharge their responsibilities, the Standards Commission for Scotland has issued a range of **Advice Notes**[27]. This includes guidance on a wide range of topics including:

- Use of social media
- Distinguishing between strategic and operational matters
- Bullying and harassment
- Declaration of interests
- Gifts and hospitality.

4.121 The role of Board Members is to provide governance, i.e., setting the direction for the organisation and overseeing the delivery of services. This primarily involves agreeing strategy and policy and holding the Executive Leadership Team to account for the delivery of the Board's purpose, aims, values, corporate objectives, operational priorities and targets. It includes managing risk, engaging with stakeholders and influencing the organisation's culture.

4.122 By comparison, the Executive Leadership Team has the primary responsibility for the implementation of change and the day-to-day management of operations. This involves the design and implementation of new ways of working that exploit research and innovation, and the planning, organising and execution involved in day to day activities and service delivery.

4.123 The line between strategic and operational matters is not always distinct, as strategic objective setting and policy setting is underpinned by operational work. In addition, some operational matters will have strategic ramifications for an organisation in terms of service delivery and risk management.

4.124 Therefore, if in doubt, Board Members should refer to the Standards Commission's advice to avoid becoming inappropriately involved in operational matters. The Board Chair should be consulted if the issue cannot be resolved following a Board Member's review of the Standards Commission's Advice Note.

4.125 It is also important to note that clinical decision making and the medical treatment of specific patients do not fall within the ambit of Board Members' governance duties.

4.126 In addition to discharging the above responsibilities, non-executive Board Members may also be required to support the business of the Board by chairing standing committees and other meetings relevant to the business of the NHS Board.

4.127 Publicly appointed members may also be appointed by the Board to represent the NHS as a voting member of the Integration Joint Boards. If it is not possible to fill the NHS positions from the publicly appointed members, Boards can nominate other members to act as voting members of the Integration Joint Boards. Stakeholder members who are councillors are excluded from this arrangement.

27 www.standardscommissionscotland.org.uk/education-and-resources/professional-briefings

4.128 Many non-executive Board Members also play a part in supporting the Executive Leadership Team's management of the organisation that goes beyond their roles as standing committee members. This can include supporting HR appeals and whistleblowing investigations. Board members may also be asked to act as Chairs for other groups where the NHS is a member.

Board Champions

4.129 The members of the NHS Board and Standing Committees can be supported in their work by a variety of colleagues acting as 'Champions' for a wide range of issues and communities. This could include equality, diversity and inclusion, mental health, whistleblowing, sustainability, global citizenship, smoking cessation, organ donation, healthy working lives and veterans.

4.130 With the exception of the Whistleblowing Champions who are appointed by the Cabinet Secretary to that role, the Champions are appointed by the Board from the non-executive membership of the NHS Board.

4.131 The principal responsibility of the Champion is to take a lead in advocating the NHS Board's commitment to being a learning organisation that focuses on improvement and the implementation of best practice in their particular area of interest. This includes raising the profile of particular issues and supporting the Executive Leadership Team in the development of appropriate policies, strategies and action plans prior to consideration by the Board.

4.132 The Champions are also available to offer a Board Member's perspective to staff networks and management teams, using this as an opportunity to share information and communicate back to the Board.

4.133 The Champions are not responsible for making operational decisions on specific issues or cases. Neither are they expected to lobby the Board for specific outcomes, but rather to ensure that relevant issues are brought to the Board's attention.

4.134 The standing committee Chairs also act as 'Champions' for the remit and functions of their committees and it is important to note that all Board Members should have an interest in the issues being considered by Champions. For example, ensuring that equality, diversity and inclusion are reflected in the Board's thinking and decision making is the responsibility of all Board Members, not just those who have a role as Equality and Diversity Champions.

Chief Executives

4.135 The description of the role and responsibilities of the Chief Executive and the one that follows for the Executive Directors, are based on work commissioned by the Scottish Government to develop a Leadership Success Profile to support recruitment and succession planning at that level of NHS Scotland.

4.136 In addition to their responsibilities as a Board Member, the NHS Chief Executive is also responsible for:

- Overseeing the development of an integrated set of policies, strategies and plans that are designed to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes focusing globally and strategically on developments that will impact upon the provision of health and social care across Scotland, and working collaboratively with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities, Health and Social Care Partnerships, and other key stakeholders to increase alignment and cohesion between government policy and the delivery of health and social care services to local communities.
- Acting as the Accountable Officer for the proper management of public funds and for ensuring the regularity, propriety and value for money in the management of the organisation. Accountability for this function is directly to the Scottish Parliament under **Section 15 of the Public Finance and Accountability (Scotland) Act 2000**[28].
- Providing leadership and day-to-day management of the organisation and its workforce, shaping desired cultural attributes within the NHS, and ensuring the organisation's policies, strategies and plans are delivered on time and within budgets. This includes building strategic and operational capability and accountability amongst the Executive Leadership Team, ensuring collective responsibility for delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Contributing to the delivery of multiple system-wide interventions at regional and national levels, whilst overseeing local delivery of change initiatives by the Executive Leadership Team. This includes encouraging and supporting research and innovation into new ways of delivering healthcare.
- Managing relationships with NHS Board Members, Scottish Government Ministers, the Director General for Health and Social Care, Senior Civil Servants and other key stakeholders involved in the delivery of health and social care. This includes establishing and enabling inclusive and effective networks at local and national level, expanding these beyond NHS Scotland and a purely healthcare focus. This is a responsibility shared with the Board Chair.

Executive Directors

4.137 The NHS Executive Directors are responsible for:

- Providing professional and expert advice and support to the NHS Board and the Chief Executive to assist in the development of the policies, strategies and plans required to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes ensuring local policies, plans and strategies are aligned to national and regional priorities for healthcare by

28 www.legislation.gov.uk/asp/2000/1/section/15

gathering insights and information from local, regional and national systems and keeping the NHS Board, executive colleagues and their directorate teams up to date with priorities and developments in the delivery of health and social care.

- Managing the integrated and collaborative delivery of services and the implementation of the organisation's plans, projects, programmes and processes within their own leadership teams and across the organisation, enabling leaders at all levels to take responsibility for delivering operational goals and performance. This includes providing collective leadership with executive colleagues for developing and sustaining the optimum culture throughout the organisation, and collaborating with system partners to empower, support and enable integrated frontline teams to operate flexibly towards the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Monitoring progress towards corporate objectives, operational priorities and targets for service delivery and managing their relationship with other key stakeholders by providing appropriate information and assurance on performance, expenditure, issues, risks and successes.
- Overseeing the delivery of multiple, interconnected and organisation-wide change interventions. This includes supporting the transformation of services at national, regional and local levels by forging relationships and supporting networks, and by engaging key stakeholders in the long term and mutual benefits of system transformation.
- Supporting the wellbeing of the workforce by providing the necessary support, training, development, and management approach required to deliver the **NHS Scotland Staff Governance Standard**[29].

4.138 Where Executive Directors are also appointed to the Board they have the same accountabilities and responsibilities as the non-executive Board Members. The same level of training and support is available to executive Board Members as is provided for the non-executive Members.

Board Secretaries

4.139 The term 'Board Secretary' is commonly used across NHS Scotland but in some NHS Boards other job titles such as 'Head of Corporate Governance' has been adopted to better describe this role. The following guidance is intended to cover the post, irrespective of the job title.

4.140 The Board Secretary has the lead role in supporting the NHS Board's approach to delivering good governance. They have the primary responsibility for ensuring the smooth operation of the governance arrangements required by the NHS Board.

4.141 The Board Secretary is responsible for:

- Leading the continuous development and implementation of the Board's governance arrangements, including the facilitation of an integrated approach to the delivery

29 www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

- of the governance systems and the provision of the operating guidance required to effectively manage these systems
- Providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance related issues
- Providing guidance to assist the Board in acting within its legal authority and statutory powers and its Members in complying with the Ethical Standards in Public Life etc. (Scotland) Act (2000) and the Code of Conduct for Members of Health Boards. This aspect of governance is explored further in the section of the guide on the behaviours expected of Board Members
- Ensuring that Board business is conducted in a spirit of openness and transparency and in accordance with any agreed Board protocol
- Communicating details of the Board's governance arrangements to ensure they are widely understood and effectively delivered by all the key players in the governance system.

4.142 Board Secretaries may also be responsible for managing the administrative and secretarial support to the Board and other governance and advisory committees.

4.143 The Board Secretaries have an informal network that facilitates the sharing of best practice and provides support to the creation and maintenance of the operating guidance for the Board and the standing committees.

Values, Behaviours and Relationships

4.144 All the members of the NHS Board should consider what is expected of them individually and collectively in terms of demonstrating the NHS Scotland values and displaying the behaviours expected of a Board Member of a public body. This includes conducting their relationships in a manner that reflects these standards.

Values

4.145 While everyone in NHS Scotland is expected to demonstrate these values, Board Members have an additional responsibility to act as role models for the rest of the workforce.

4.146 **Board Members are expected to demonstrate and uphold the core values of NHS Scotland, as published in the 2020 Workforce Vision 'Everyone Matters'[30]. These are defined as:**

i. Care and compassion
ii. Dignity and respect
iii. Openness, honesty and responsibility
iv. Quality and teamwork.

30 www.gov.scot/publications/everyone-matters-2020-workforce-vision/

Behaviours

4.147 NHS Boards must act morally, ethically and fairly if they are to deliver good governance in healthcare. In common with all public bodies in Scotland, Boards are required to have in place a Code of Conduct that sets out the standards of behaviours expected of their Board Members.

4.148 To support the delivery of the requirements set out in the **Ethical Standards in Public Life etc. (Scotland) Act (2000)**[31], the Scottish Government's Public Bodies Unit has developed a Code of Conduct specifically designed for Members of Health Boards. This not only sets out how the provisions of the Code should be interpreted and applied in practice, it also gives guidance on the rules regarding remuneration, allowances, expenses, gifts and hospitality, lobbying, registration of interests and the confidentiality of information.

4.149 **The Code of Conduct for NHS Board Members is based on the Model Code of Conduct for Members of Devolved Public Bodies**[32] **approved by the Scottish Parliament on 7 December 2021. This has been developed in line with the Principles of Public Life in Scotland. These are:**

i. **Duty** – Members have a duty to uphold the law and act in accordance with the law and the public trust placed in them. They have a duty to act in the interests of the public body of which they are a member and in accordance with the core tasks of that body.
ii. **Selflessness** – Members have a duty to take decisions solely in terms of public interest. They must not act in order to gain financial or other material benefit for themselves, family or friends.
iii. **Integrity** – Members must not place themselves under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence them in the performance of their duties.
iv. **Objectivity** – Members must make decisions solely on merit when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.
v. **Accountability and Stewardship** – Members are accountable for their decisions and actions to the public. They have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.
vi. **Openness** – Members have a duty to be as open as possible about their decisions and actions, giving reasons for their decisions and restricting information only when the wider public interest clearly demands.
vii. **Honesty** – Members have a duty to act honestly. They must declare any private interests relating to their public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

31 www.legislation.gov.uk/asp/2000/7/contents
32 www.standardscommissionscotland.org.uk/codes-of-conduct/members-model-code-of-conduct

viii. **Leadership** – Members have a duty to promote and support the Principles of Public Life in Scotland by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

ix. **Respect** – Members must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly they must respect members of the public when performing duties as a member of your public body.

4.150 The Standards Commission has produced **Guidance on the Code of Conduct**[33] to help Board Members interpret and adhere to the provisions in the Code and to attain the highest possible standards of conduct.

4.151 NHS Boards must adopt the Code of Conduct, having first obtained Scottish Government's approval for any amendments to the draft proposed by the Public Bodies Unit. The Board should then formally record their acceptance of the Code of Conduct for Members of their Board. This should then be reflected in the Standing Orders required to support their governance arrangements.

Relationships

4.152 Building and maintaining effective working relationships are critical to the delivery of good governance. Board Members should consider and constantly review their own and the NHS Board's relationships with the other stakeholders in the health and social care system.

4.153 Board Members must apply the values of NHS Scotland and the principles of the Code of Conduct for Members of Health Boards in their dealings with fellow members of the Board, its employees and other stakeholders. The Board Chair has a responsibility to ensure that Members receive the necessary support to act in the appropriate manner at all times.

4.154 To support collaborative working relationships and assist in the conduct of Board business a Board Protocol may be introduced to ensure that best use is made of the time and the contribution of the Board Members. Highlighting the rules or etiquette for the conduct of meetings can assist Chairs to ensure the views of Members are heard and meetings are conducted in a manner consistent with the NHS Scotland values and the Code of Conduct for NHS Board Members.

4.155 The introduction of a Board Protocol should also help Members to make enquiry and challenge the executives in an appropriate manner, ensuring a healthy relationship exists between Board Members and the Executive Leadership Team.

4.156 Defining the functions and enablers of the governance approach is not enough to ensure good governance. To embed the Principles of Good Governance, NHS

33 www.standardscommissionscotland.org.uk/guidance/guidance-notes

Boards must also implement, maintain and continuously improve cohesive governance arrangements that are specifically designed to deliver this approach at Board level. The following sections of the guide describe how NHS Boards should go about delivering those aspects of the Blueprint for Good Governance.

The Delivery Approach

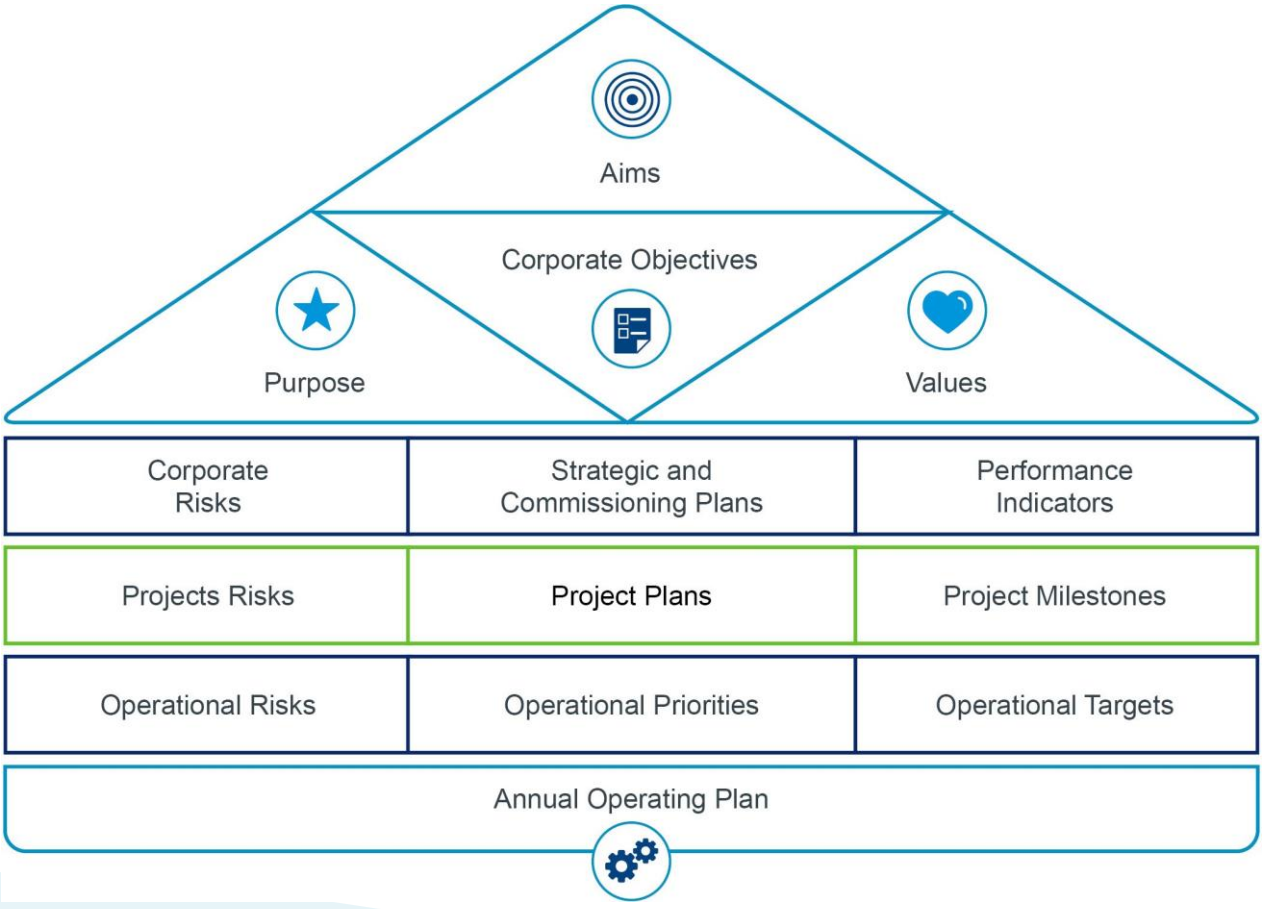
4.157 To support the delivery of good governance NHS Boards should construct an assurance framework and implement an integrated governance system that brings together the organisation's strategic planning, risk management and assurance information systems.

4.158 The assurance framework and integrated governance system must be supported by a suite of operating guidance and it is critical to the delivery of good governance that these arrangements are widely communicated across the organisation.

The Assurance Framework

4.159 Promoting and delivering good governance starts with the development of an assurance framework. This simple model brings together the organisation's purpose, aims, values, corporate objectives and risks with the strategic plans, change projects and operating plans necessary to deliver the desired outcomes.

Figure Two – The Assurance Framework



4.160 The assurance framework is primarily used to identify and resolve any gaps in control and assurance and helps identify any areas where assurance is not present, insufficient or disproportionate in relation to the delivery of the NHS Board's corporate objectives or operational priorities.

4.161 The construction of the assurance framework also ensures the systems introduced for strategic planning and commissioning, implementing change, managing risk and providing assurance information are all aligned and focused on the corporate objectives and operational priorities.

4.162 The assurance framework also describes the performance indicators, change project milestones and targets linked to each of the corporate objectives and forms the foundations for the assurance information system that provides the accountability reports to the NHS Board and standing committees.

4.163 Once completed, the framework provides a clear picture of the links between the outcomes expected by the Board and the strategic plans, transformational change projects and operational plans developed by the Executive Leadership Team to deliver those outcomes. It describes which objectives and what risks are delegated (in the Scheme of Delegation) to each of the standing committees. This ensures that both the delivery of strategic and transformational change and the current operational outputs and outcomes are subject to appropriate scrutiny, at the appropriate level and in the appropriate place within the governance system.

4.164 In practice, the application of the assurance framework means that longer-term strategic issues and risks are considered in a holistic fashion by the Board, with the standing committees focusing on the delivery of delegated, specific corporate objectives, operational priorities and the more immediate annual operating plans.

4.165 To further enhance this approach and support collaborative governance, it is important that the territorial Boards also take account of the strategic and commissioning plans and the annual accountability reports produced by the local Integration Authorities when developing their assurance frameworks.

4.166 Introducing an assurance framework also helps executives, managers and staff better understand how the organisation is governed and their role and accountabilities within the governance system. It emphasises the division of responsibilities between the Board and the Executive Leadership Team.

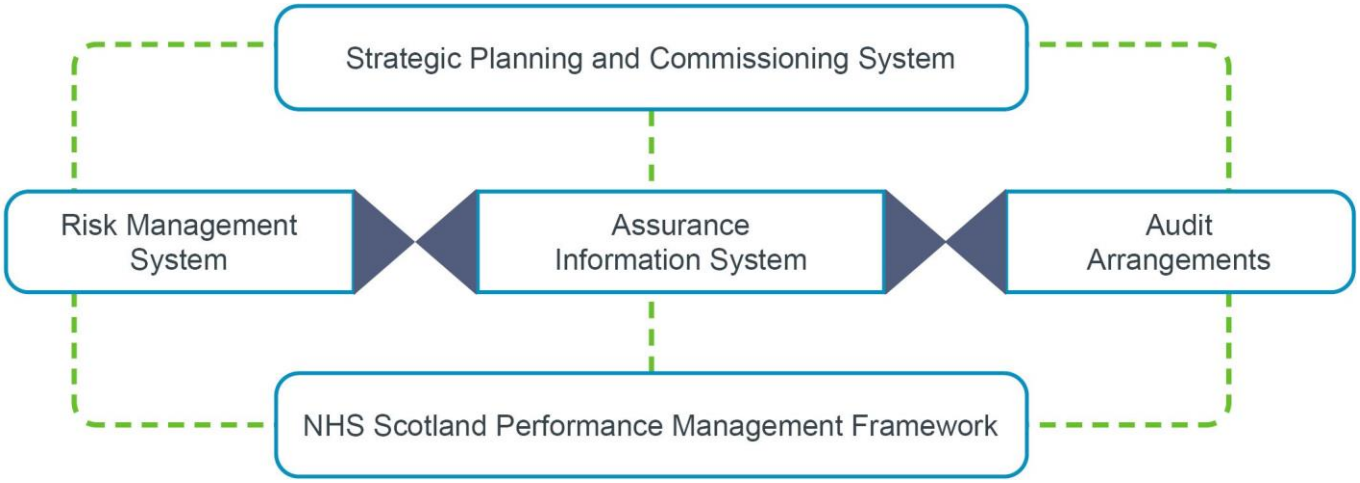
4.167 NHS Boards should go beyond simply constructing an assurance framework to deliver good governance. The framework has to be implemented effectively for it to be of value. This is explored further in the next sections of the guide that relates to the integrated governance system.

The Integrated Governance System

4.168 Integrated governance requires an all-encompassing approach to the delivery of the services provided by the organisation. It brings together the distinct governance systems required to direct and control the management of operations and the leadership of change, and the effective integration of these systems is critical to the delivery of the active and collaborative approaches to governance.

4.169 In NHS Scotland there are five discrete but linked assurance systems that can be considered as the integrated governance system that supports the delivery of good governance.

Figure Three – The Integrated Governance System



4.170 These systems primarily assist the NHS Board in setting the direction, holding the Executive Leadership Team to account and managing risk. They can also play an important part in delivering the assurance required in relation to the stakeholder engagement and influencing culture functions of the Board.

4.171 The Board shares ownership of the strategic planning and commissioning system with the Integration Authorities and has accountability for the risk management system, the assurance information system and the audit arrangements. The Scottish Government owns the NHS Scotland Performance Management System.

4.172 Collectively, these systems provide the Scottish Government, the NHS Board, the standing committees and the Integration Authorities with important information that helps them to be assured that good governance is in place across the healthcare system.

4.173 A more in-depth description of the component parts of the integrated governance system is included in the supplementary guidance attached as an appendix to the guide.

4.174 While the introduction of an assurance framework and the development of an integrated governance system will contribute significantly to the delivery of the active and collaborative approaches to governance, the delivery of good governance also relies on efficient operating arrangements being implemented throughout the organisation. How NHS Boards should achieve this outcome is described in a suite of documents described in the Blueprint for Good Governance as operating guidance.

The Operating Guidance

4.175 The detailed description of the NHS Board's governance arrangements and the guidance on implementing these arrangements are contained in a portfolio of documents that is developed, maintained and communicated by the Board Secretary. It includes Standing Orders, Standing Financial Instructions and the Schemes of Delegation that provide the senior leadership and management of the NHS with their principal operating guidance.

Figure Four – The Operating Guidance

4.176 Additional guidance is available from the Board Secretaries Group to support the efficient delivery of the NHS Board's proceedings and business, including terms of reference for committees and templates for agendas and minutes of meetings.

4.177 Board Secretaries can also provide guidance on how Boards should develop their Annual Cycle of Business for the Board and the standing committees that delivers an integrated work programme and coordinated timetable for Board meetings, Board seminars and standing committee meetings.

4.178 Guidance on the drafting of papers and reports, including security classification and setting the requirements for financial, risk and equality assessments of the impact of options presented to the Board is also required to ensure the smooth operation of Board and committee meetings.

4.179 To supplement the guidance in the Code of Conduct for NHS Board Members, the suite of operating instructions available to Board Members may also include a locally agreed Board Protocol for the chairing, conduct and reporting of meetings.

4.180 In the territorial Boards the operating requirements for those functions delegated to the Integration Authorities are described in the Integration Schemes agreed between the NHS Boards and the Local Authorities. This document also provides Board Members with guidance on the delivery of the collaborative governance arrangements for the healthcare functions delegated to the Integration Joint Board. As such, they should be seen as an important component of the NHS Board's operating guidance.

4.181 With the exception of the Integration Scheme(s), the documents that make up the Operating Guidance should be reviewed annually by the Boards to coincide with the preparation of governance statement that forms part of the Annual Report.

4.182 **The Public Bodies (Joint Working) (Scotland) Act 2014**[34] requires Local Authorities and Health Boards to review their Integration Schemes before the expiry date, which is five years after the scheme was approved in the Scottish Parliament. The Scottish Government is responsible for facilitating parliamentary approval of any revisions to the Integration Schemes.

4.183 In addition to the standard portfolio of operating guidance described above, some Boards may also have other material that describes how the system of governance works within their particular organisation. Board Members should be aware of these local instructions and take them into account when carrying out their role.

4.184 Further information on best practice in healthcare governance can be found at the websites provided by **NHS Scotland**[35] and **NHS Education for Scotland**[36].

4.185 Having considered what needs to be done to ensure good governance, it is important to consider how the NHS Boards and the Scottish Government will determine whether or not this approach has been successful. Therefore, the next

34 www.legislation.gov.uk/asp/2014/9/contents
35 www.nhs.scot
36 www.nes.scot.nhs.uk

section of the guide describes the evaluation process for the governance of NHS Scotland.

The Evaluation Approach

4.186 In order to assess the effectiveness of the healthcare governance system and whether or not it is continuously improving, it is important to have a consistent and systematic approach to assessing and evaluating the NHS Boards' governance arrangements against the Principles of Good Governance.

4.187 The approach to evaluation must provide assurance to the Board, the Scottish Government and the other stakeholders in healthcare that good governance is being delivered across all the categories of governance in healthcare.

4.188 For NHS Scotland the preferred approach to evaluation involves three levels of assessment:

- Appraisal of the Board Members' individual performance
- Self-assessment of the Board's effectiveness
- External review of the organisation's governance arrangements.

These activities should be viewed as a means of supporting personal and Board development, rather than a punitive process.

4.189 The following paragraphs describe each level of the evaluation approach and how they are brought together to inform and drive a programme of improvement activities.

Individual Performance Appraisal

4.190 The Scottish Government is responsible for developing and implementing the performance appraisal system for Chairs and other NHS Board Members.

4.191 The Director General for Health and Social Care carries out the appraisal of NHS Board Chairs on behalf of the Cabinet Secretary. This process includes a self-assessment by the Chair and a 360 degree feedback exercise involving Board Members, executives and other stakeholders.

4.192 The Board Chair reports to the Scottish Government on the contribution made to the work of the Board by its Members. The format of these reports is set by the Government and includes discussions on personal development opportunities that might be used to enhance the individual's effectiveness as a Board Member.

4.193 The NHS Board Chair should consider how any weaknesses in the governance arrangements identified through the individual performance appraisal systems can be addressed by the Board.

Board Self-Assessment

4.194 NHS Boards should regularly review their governance arrangements and annually conduct a structured self-assessment to review their effectiveness, identifying any new and emerging issues or concerns.

4.195 The Principles of Good Governance form the basis of the Board's self-assessment and this exercise should provide a view of the extent to which the Blueprint for Good Governance has been implemented across the organisation. This should include an evaluation of the current status of the systems that support the organisation's governance arrangements.

4.196 To ensure that the criteria against which the Board's assessment is valid, reliable and transparent and reflects best practice in governance, the Scottish Government provide NHS Boards with advice and guidance on how to conduct the self-assessment exercise.

4.197 After critically examining the findings of the self-assessment exercise, the Board should use this information as the baseline and driver for its improvement and development activities.

External Review

4.198 To enhance and validate the Boards' self-assessments, a systematic evaluation of the governance arrangements across the NHS Boards should be undertaken by an external specialist in governance.

4.199 The Scottish Government are responsible for commissioning and managing a programme of structured governance reviews that includes a work plan to evaluate the NHS Boards' governance arrangements at least every three years.

4.200 In undertaking these reviews the external specialist will bring together a range of evidence from a number of sources and include benchmarking the NHS Board's governance with comparative healthcare organisations and the latest thinking on best practice in governance.

4.201 NHS Boards and the Scottish Government can also commission ad hoc thematic reviews of specific areas of governance, e.g., clinical governance or risk management.

4.202 The Board should compare the findings of the external reviews, with the output of the Board's self-assessment exercise and the view of the governance arrangements gained from the individual performance reviews. This combination of information should then be used to inform and support the continuous improvement approach to governance described in the final section of the guide.

The Improvement Approach

4.203 For the governance of healthcare to continuously improve, the approach adopted by NHS Scotland has to be an evolving, iterative and integrated process that is widely understood and adopted by the NHS Boards.

4.204 The following paragraphs describe the quality improvement approach required by the NHS Boards, NHS Education for Scotland and the Scottish Government to ensure that the governance arrangements in NHS Scotland remain relevant and continue to be fit for purpose as the health and social care system evolves over time.

NHS Boards

4.205 Having assessed the effectiveness of the organisations governance arrangements by triangulating information from individual performance reviews, the Board self-assessment and external reviews, the NHS Boards must design and implement a bespoke programme of activities to address the issues and concerns raised by the evaluation process.

4.206 The activities included in the Board's improvement programme should focus on the delivery of the Principles of Good Governance and be described in terms of enhancements to the enablers and delivery systems in the Blueprint for Good Governance.

4.207 The improvement programme must include actions to address any shortcomings in the recruitment, induction, training and development of Board Members that surfaced at individual performance reviews. It must respond to the findings of the self-assessment of Board effectiveness by including work to overcome any weaknesses identified by the Board Members. Any recommendations for improvement in the governance arrangements from external reviews or other sources should also be added to the programme plan.

4.208 The Board's improvement programme plan should be published and details of the progress made to implement the actions outlined in the plan should be regularly reported to the NHS Board and discussed at the NHS Board's Annual Review with the Scottish Government.

NHS Education for Scotland

4.209 NHS Education for Scotland has a significant role in improving the delivery of good governance in the NHS by supporting NHS Boards to respond positively to the findings of the internal and external evaluation of their governance arrangements.

4.210 This support is primarily delivered through a comprehensive programme of development activities that includes a range of support material, training courses, seminars and workshops designed to support NHS Boards in improving their governance arrangements. This includes induction training and broader development opportunities tailored to individual Boards and Board Members' needs, a mentoring scheme for Board members and a development programme for aspiring Chairs and Vice Chairs.

4.211 The training and development material offered by NHS Education for Scotland is regularly updated to reflect best practice in healthcare governance and is supported by a digital portal which offers practical resources to support Board Members' continuous personal development. This is accessed through the TURAS Learn system on the **NHS Scotland Board Development**[37] website and all Board Members are expected to register on the TURAS Learn system and take advantage of the opportunities for developing their skills as Board Members.

4.212 The support provided by NHS Education for Scotland to NHS Boards and individual Board Members is a valuable resource and should be incorporated as appropriate into the Board's improvement programme.

Scottish Government

4.213 To ensure that good governance is being delivered across NHS Scotland in a consistent manner, the Directorate for Finance and Governance works with NHS Boards to achieve continuous improvement in their governance arrangements. This includes commissioning and approving the national induction and the other training and development material on governance in healthcare that is delivered by NHS Education for Scotland and other training providers.

4.214 The Scottish Government also supports the continuous improvement approach by providing advice and guidance to NHS Boards on specific governance issues and its website contains valuable information to support Board Members in delivering their roles and responsibilities.

4.215 To guide and support the improvement of governance in NHS Scotland, the Director of Health Finance and Governance has put in place a Healthcare Governance Advisory Board. This replaces the NHS Scotland Corporate Governance Steering Group.

4.216 The purpose of the Healthcare Governance Advisory Board is to provide leadership, support and guidance to key stakeholders by advising on the development and implementation of the delivery of good governance in healthcare across NHS Scotland. The remit of the Advisory Board includes providing input to the development of the policies and initiatives required to ensure a continuous improvement approach is adopted to governance in NHS Scotland.

37 **https://learn.nes.nhs.scot/17367/board-development**

4.217 The Advisory Board reports to the Director of Health Finance and Governance and its membership includes a Chair appointed by the Scottish Government and representatives from the key stakeholders in healthcare governance. This may include independent advisors to bring an external perspective to the work of the Board and other members of NHS Scotland may be invited to join as and when specific expertise is required on the Advisory Board.

4.218 The description of the support for a continuous improvement approach to governance in healthcare in the previous paragraphs completes the guide to the Blueprint for Good Governance.

4.219 The publication of this document should ensure that Board Members, Executive Leadership Teams and other stakeholders in the governance of NHS Scotland have a shared understanding of the importance and definition of good governance and appreciate the role that active, collaborative and continuous improvement approaches play in the delivery of the Blueprint.

4.220 Although the guide describes the functions, enablers, delivery, evaluation and improvement approaches that make up the Blueprint for Good Governance, supplementary guidance has been appended to this document to provide further, more detailed guidance on the delivery of the Integrated Governance System require to implement and sustain good governance across the NHS.

Supplementary Guidance

A. The Strategic Planning and Commissioning System

A.1 In setting the direction for the healthcare system, strategic and commissioning plans should clearly set out the drivers for change, the consultation and engagement undertaken, and the vision of the future that should result from implementing the strategies and services described in the plans.

A.2 Strategic and commissioning plans must be aligned to the NHS Board's purpose, aims and values. The corporate objectives being supported and the outcomes expected from the delivery of these plans should be clearly stated.

A.3 The development of strategies and changes to service delivery models should include appropriate stakeholder engagement, particularly when a proposed service change will have a major impact. NHS Boards must ensure that when necessary, stakeholder engagement is carried out at the outset of the planning and commissioning process and this engagement is inclusive, proportionate and robust. Advice from **Healthcare Improvement Scotland Community Engagement**[38] is available to NHS Boards to ensure that they have met the national standards for engagement.

A.4 In addition to describing the need for change and the expected outcomes, strategic and commissioning plans should also include details of the business case behind this approach. A cost- benefit analysis of proposed changes gives Board Members one of the key pieces of information required to approve the plans.

A.5 Board Members also require assurance around the implementation of the strategic and commissioning plans. As these will usually require a degree of transformational change, Boards should ensure that the organisation has the capability and capacity to support the delivery of the change projects and programmes. This is necessary to not only deliver the planned changes, but also to ensure the realisation of the benefits expected from the strategic and commissioning plans.

A.6 The Board should seek assurance that implementation plans and change projects and programmes include comprehensive risk assessments, equality impact assessments and communication plans that will support the delivery of strategic plans and change projects and programmes.

38 www.hisengage.scot

A.7 The implementation plans should also be clear about how success will be measured and the governance arrangements for oversight of delivery, including details of the information flows to the Board Members on the progress being made with implementation. This should include any arrangements for evaluation of the effectiveness of new approaches during and at the end of the period covered by the plan.

A.8 It is also important that Board Members consider the extent to which corporate strategies and change projects and programmes take advantage of research and innovation in science and technology.

A.9 Who has the overall accountability for the delivery of the strategy and who are the individuals responsible for delivering specific change projects and programmes should also be considered by Board Members. It will be important that the Board is assured that the organisation has the personnel in place with both the capability and the capacity to meet these requirements.

A.10 NHS Boards should put in place a strategic planning cycle that clearly indicates where and when the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans. To facilitate this approach, a strategic planning framework should be maintained.

A.11 For each of the strategic and commissioning plans, the strategic planning framework should describe the period covered and the corporate objectives addressed by the plan. It should also identify the stakeholders consulted, the author, the approver and the date approved. Details of the reporting arrangements and the expected date of the next review by Board Members should also form part of the framework.

A.12 Given the close relationship between healthcare and social care services and the integrated approach to delivering these services required by NHS Boards and Local Authorities in Scotland, it is critical to the effective planning and commissioning of primary and secondary healthcare that the plans developed by the Integration Authorities align with the strategic plans approved by the NHS Board.

A.13 **The Public Bodies (Joint Working) (Scotland) Act 2014**[39] introduced a statutory duty for NHS Boards and Local Authorities to integrate the planning and delivery of delegated health and social care functions across Scotland. Therefore, it is essential that NHS Boards play their part in the development of the Integration Authorities strategic commissioning plans as set out in the 2014 Act. This requires Integration Authorities to establish a Strategic Planning Group, and the NHS Board must nominate a minimum of one person to join that group. That requirement should feature in the Integration Scheme agreed between the NHS Board and the Local Authority.

39 www.legislation.gov.uk/asp/2014/9/contents

A.14 The NHS Boards should include details of the Integration Authorities strategic commissioning planning process in their strategic planning framework. This should highlight the dependencies between plans that need to be managed by the NHS Chief Executive and the Health and Social Care Partnership's Chief Officer(s).

A.15 NHS Boards also have responsibilities under the **Community Empowerment (Scotland) Act 2015**[40] for working together with local communities to plan and deliver better services that make a real difference to people's lives.

A.16 The NHS Boards' involvement in the Community Planning Partnerships across Scotland is intended to ensure that service planning is co-ordinated at a local level. Therefore, Boards should take into account the views, ambitions and priorities of the Community Planning Partnership when developing their strategic and commissioning plans.

A.17 This inclusive and collaborative approach to designing and maintaining an overview of strategic planning and commissioning should ensure that the NHS Board can be assured that the organisation's aims are being pursued and the full range of corporate objectives are being addressed by those responsible for the delivery of healthcare in their area.

A.18 The NHS Board's strategic and commissioning plans should be aligned with any relevant operational policies in place to support the delivery of healthcare services. Boards should ensure that operational policies are subject to approval and regular review by the Board and the standing committees. To manage this in a co-ordinated manner a policy framework should be established and maintained for all significant healthcare policies. The policy framework should provide Board Members with the same information on policy development that the strategic planning framework does on strategic and commissioning plans.

A.19 Effective strategic planning and policy development must include assessment of the risks existing in the healthcare system and the next section of the supplementary guidance focuses on that aspect of the integrated governance system.

40 www.legislation.gov.uk/asp/2015/6/contents

B. The Risk Management System

B.1 Risk management is an integral part of the active and collaborative approaches to delivering good governance. It enhances strategic planning and prioritisation, assists in achieving corporate objectives and strengthens the Board's ability to be agile in response to the challenges faced by the NHS.

B.2 NHS Boards cannot be entirely risk averse, and having an effective and meaningful risk management system that systematically anticipates and prepares successful responses to the uncertainties faced by NHS Boards is critical to delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

B.3 When considering their approach to risk management, NHS Boards should recognise that it is often not possible to manage all risks at any point in time to the desirable tolerance level. Very often it is also not possible, and not financially affordable, to fully remove uncertainty from decisions. Therefore, Boards should encourage and support a risk culture that embraces openness, supports transparency, welcomes constructive challenge and promotes collaboration, consultation and co-operation.

B.4 The principles and concepts that support effective risk management are outlined in **HM Government's Orange Book**[41] and the **Scottish Public Finance Manual**[42] provides guidance on best practice for risk management in the Scottish public sector.

B.5 Almost all processes, procedures and activities carried out by the NHS carry with them a degree of risk. So, it is necessary for the NHS Board to agree the level of risk with which it aims to operate, based on what it considers to be justifiable and proportionate to the impact on patients, service users, the public, the workforce and the Board. Consequently, understanding and communicating the Board's risk appetite is the first step in constructing an effective risk management system.

B.6 Guidance on the development and use of a risk appetite statement is contained in **HM Government's Risk Appetite Guidance Notes**[43]. Having agreed their risk appetite, NHS Boards must then develop, maintain and continuously improve a risk management system that supports the achievement of the Board's corporate objectives and operational priorities while remaining within its risk appetite.

41 www.gov.uk/government/publications/orange-book
42 www.gov.scot/publications/scottish-public-finance-manual
43 assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012891/20210805_-_Risk_Appetite_Guidance_Note_v2.0.pdf

B.7 The risk management approach adopted by the organisation must include activities and processes that facilitate the identification of corporate and operational risks and supports the assessment, mitigation, monitoring and reporting of these risks.

B.8 The risk management system should be utilised in a way that assists the NHS Board and the Executive Leadership Team to prioritise available resources to minimise risk to best effect and to provide assurance that progress is being made. This must include the maintenance of a tiered set of operational and corporate risk registers to quantify and prioritise risks which threaten the achievement of the organisation's objectives and priorities.

B.9 The purpose of the risk registers is to achieve greater visibility of exposure to risk across the categories identified in the risk appetite statement and as a result reduce the likelihood that risks will occur or evoke an effective response when risks occur. Therefore, it is important that the risk registers are constantly updated to reflect the dynamic nature of delivering healthcare.

B.10 For the risk registers to be an effective tool for the management of risk it is important that they include an articulation of the risk event itself, details of the underlying causes (including internal and external factors), and the range of consequences should the risk event occur.

B.11 The risk registers should include an assessment of the combination of the consequences of the event (impact) and its probability (likelihood). The impact should be the estimated effect of the risk on the objectives in question. This assessment is focused on scale, scope and resource implications. Likelihood is the estimated chance of the risk occurring. This is focussed on probability.

B.12 Having assessed the risk, the response should be to either treat, tolerate, or terminate the risk. The mitigation actions already taken or proposed to respond to the risks to be treated, should also be described in the registers. This should include the owner of the action, the timescales involved and where the oversight and scrutiny of the delivery and outcome of the mitigation sits within the organisation's hierarchy.

B.13 To highlight the expected changes to the impact and likelihood of the risk materialising, the assessment scores should be included pre and post the mitigation actions.

B.14 The development of business continuity plans are often used to mitigate some corporate risks, including those around the loss of IT systems, disruption to water, gas and electricity supplies, and other failures in the physical infrastructure. These plans are designed to ensure that the organisation can continue to operate and recover should a significant risk materialise. They aim to increase resilience across the healthcare system by responding to identified risks with an impact assessment and contingency plans that have been implemented and tested across the organisation.

B.15 Therefore, NHS Boards must ensure that appropriate business continuity plans are in place, regularly tested and reviewed, and widely communicated with the appropriate stakeholders.

B.16 Where the delivery of services provided by organisations outside of the NHS Board can introduce risk to the delivery of healthcare, it is important that the NHS approach to risk management and business continuity planning recognises this and responds appropriately. This is particularly important in the delivery of integrated health and social care systems and requires Board Members who also sit on the Integration Joint Boards to pay particular attention to the impact mitigating healthcare risks can have on social care services and vice versa.

B.17 The information presented in the risk registers and the business continuity plans should improve decision making and assist the NHS Board to assess whether or not management controls and resources deployed are adequate to effectively manage corporate and operational risks in healthcare.

B.18 Responsibility and accountability for the operation and the oversight of the risk management system should be clearly defined and responsibility for contributing to the management of risks should be included in the job descriptions of staff, the terms of reference of the governance committees and the Board's Scheme of Delegation.

B.19 Not only do NHS Boards require assurance on the effectiveness of their approach to strategic planning and risk management, they need to commission an assurance information system that provides them with the necessary information to give Board Members assurance on the progress being made towards the delivery of the organisation's strategic, operational and financial plans.

C. The Assurance Information System

C.1 The assurance information system should be designed to provide frequent and informative performance and financial reports to assure the Board that it is delivering safe, effective, patient- centred, affordable and sustainable services. This system should deliver relevant, accurate and timely information on a wide range of activities, including:

- Service delivery
- Safety and quality standards
- Innovation and transformational change
- Workforce
- Education, training and development
- Finance.

C.2 NHS Boards should agree with the NHS Chief Executive the contents of the assurance information system required by the Board and the standing committees. This should include information on both the management of current operations and the progress being made to deliver change across the healthcare system.

C.3 How data should be presented in order to assist those preparing papers for Board Members' scrutiny should also be agreed with the NHS Chief Executive and in the case of territorial NHS Boards, with the Health and Social Care Partnership's Chief Officer(s).

C.4 Board papers should show data in a clear, consistent and effective way to ensure that Board Members are able to understand and interpret its significance and receive the level of assurance required. Best practice in presenting data includes:

- Presenting statistical information in charts or tables, rather than in a narrative format
- Including actual numbers rather than percentages, although there will be times where both are appropriate
- Limiting the volume of information shown as charts and tables that have too much information can mean that key messages are lost or difficult to see
- Ensuring units of time are consistent for comparative purposes, e.g., months have variable number of days but weeks always have the same number of days
- Using line charts to measure change or performance over time and if variation is a potential concern, add a target line or convert to a control chart
- Favouring control charts to show if variation is within normal limits and therefore not necessarily a concern
- Describing a position at a point in time by allocating RAG status but these should be used with caution as RAG charts could focus attention on lower priorities
- Benchmarking results using pareto charts which are preferable to pie charts

- Comparing results using funnel charts helps to identify special cause variation, i.e. one not typically expected
- Compiling a whole system view by presenting a series of charts showing different aspects of performance within the same area, giving a more comprehensive and thorough overview
- Including forecasts in tables and charts to describe what results are predicted with the resources available and in the circumstances expected
- Adding trajectories when a changing level of performance over time is required, often by the body commissioning the work.

C.5 Further guidance on the presentation of data to Board Members can be obtained from NHS Education for Scotland's material on the implementation of the active approach to delivering good governance.

C.6 While data and management information provides Board Members with a particular view of the organisation, to deliver good governance this has to be triangulated with other reports and the more qualitative information available on service delivery.

C.7 Therefore, the assurance information system should incorporate other regular internal reports on the operation of the healthcare system, particularly those that reflect patient, service user and staff experience. Examples of this category of assurance information sources would include the following:

- Healthcare Acquired Infection Report
- Complaints Report
- Duty of Candour Annual Report
- Public Health Screening Programme Annual Report
- Vaccination Programme Annual Report
- Child Poverty Action Plans Progress Report
- Research and Development Annual Report
- iMatter Reports
- Whistleblowing Annual Report.

C.8 It is important that this list is seen as simply an example and the majority of reports included are relevant to territorial Boards. Consideration of these reports by the Board or the appropriate standing committee should form part of the Annual Cycle of Business or in the case of the ad hoc reports, be reviewed at the earliest opportunity.

C.9 The Assurance Information System should also incorporate the wide range of external reports available to Boards. These include one-off Audit Scotland reports on various aspects of the health and social care system, Health Improvement Scotland reviews, Care Opinion feedback, Mental Welfare Commission reports, Scottish Public Services Ombudsman's reports, NHS Education for Scotland Deanery Reports and the General Medical Council's reports on the training of junior doctors.

C.10 Board Members should be aware that the specific issues raised in these reports may signal wider concerns. For example, GMC reports on the training of junior doctors can potentially highlight wider issues concerning patient safety and the standard of care, thus providing an opportunity for early intervention and remedial action.

C.11 NHS Boards should also closely scrutinise the reports prepared for the Board's Annual and Mid- Year Reviews with the Scottish Government and pay particular attention to the Annual Reports submitted to the Scottish Government by the Health and Social Care Partnerships. These documents combine to give a comprehensive account of the progress made by the organisation across both Primary and Secondary Care and should provide Board Members with assurance on the progress being made to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

C.12 In additional to scrutiny of internal and external reports NHS Boards should also pay attention to the feedback to NHS Boards from the **Sharing Intelligence for Health and Care Group**[44]. This group is responsible for supporting improvement in the quality of care provided for the people of Scotland and its main objective is to ensure that any potentially serious concerns about a care system are shared and acted upon appropriately. The feedback from the group also highlights examples of where things are working well.

C.13 Feedback from a structured visiting programme by Board Members to frontline services and online discussions with patients, service users and staff should also feature in the assurance information system, enabling the quantitative data and the external perspective to be considered against the Board Members' impression of the patient and staff's views of the organisation.

C.14 In addition to having effective strategic planning, risk management and flows of assurance information to the NHS Board, an integrated approach to delivering good governance also relies on having effective internal and external audit arrangements.

44 www.healthcareimprovementscotland.org/our_work/governance_and_assurance/sharing_intelligence.aspx

D. The Audit Arrangements

D.1 The integrated governance system includes the audit arrangements required to provide the Board and key stakeholders with assurance that the system of internal controls is functioning as intended.

D.2 The main contributors to the audit arrangements are the NHS Board, the Internal Auditors, the External Auditors and the Audit and Risk Committee.

D.3 NHS Boards have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity. This includes ensuring that accurate accounting records are maintained and financial statements are prepared that give a true and fair view.

D.4 **The Code of Audit Practice (2021)**[45] prepared by Audit Scotland sets out the respective functions and responsibilities of the internal and external auditors.

D.5 Internal audit is a function of management and it operates under the **Public Sector Internal Audit Standards**[46]. This defines internal auditing as an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. To deliver these outcomes the role the internal audit team should include:

- Reviewing accounting and internal control systems
- Reviewing the economy efficiency and effectiveness of operations
- Assisting with the identification of significant risks
- Examining financial and operating information
- Special investigations
- Reviewing compliance with legislation and other external regulations.

D.6 To ensure that internal audit is an independent and objective assurance activity, the Board should seek assurance that the internal auditors are independent of executive management and should not have any involvement in the operations or systems they audit. The Head of Internal Audit should report to the Chief Executive or one of their direct reports. They also should report functionally to the audit committee and have right of access to the Chair of the Audit and Risk Committee, the Chief Executive and the NHS Board Chair. These arrangements should be clearly set out in the Board's Standing Financial Instructions and the terms of reference for its Audit and Risk Committee.

45 www.audit-scotland.gov.uk/publications/code-of-audit-practice-2021
46 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

D.7 External audit provides independent challenge and assurance on the Board's annual accounts and provide a view on matters relating to regularity, propriety, performance and the use of resources. NHS Boards are assigned external auditors by the Auditor General for Scotland who is a Crown appointment and is independent of Government. The responsibilities of independent auditors are established by the **Public Finance and Accountability (Scotland) Act 2000**[47] and the **Code of Audit Practice**[48] and their work is guided by the **Financial Reporting Council's Ethical Standard**[49].

D.8 The key responsibilities of the external auditors can be summarised as follows:

- To give an independent opinion on the financial statements and other information within the annual report and accounts
- To review and report on the arrangements within the audited body to manage its performance, regularity and use of resources
- To support improvement and accountability.

D.9 To deliver the internal and external audit functions, an annual audit programme should be put in place to deliver a comprehensive portfolio of system audits that ensures the main contributors are all able to meet their statutory responsibilities and the NHS Board and the Scottish Government can be assured on the effectiveness of the management, leadership and governance of the organisation.

D.10 The audit plans included in the programme should document how the internal and external auditors intend to meet their responsibilities and it is important that these plans are joined-up, effective and proportionate. They should be linked to the delivery of corporate objectives and operational priorities and should focus on the areas identified as corporate and operational risks.

D.11 The Board's Audit and Risk Committee has a key role in ensuring the effectiveness of the internal audit functions including:

- Overseeing the selection process for new internal auditors
- Reviewing and agreeing the annual internal audit work plan
- Ensuring recommendations are actioned by the Executive Leadership Team
- Disseminating audit reports to the relevant Board committees
- Encouraging the use of audit reports as improvement tools
- Monitoring and assessing the effectiveness of the audit team
- Making recommendations to the Board for the award of the internal audit contract and the appointment and termination of the Head of Internal Audit
- Overseeing the Board's relations with the external auditors, including reviewing the scope of their annual audit plan.

47 www.legislation.gov.uk/asp/2000/1/contents
48 www.nao.org.uk/code-audit-practice
49 www.frc.org.uk/getattachment/0bd6ee4e-075c-4b55-a4ad-b8e5037b56c6/Revised-Ethical-Standard-2016-UK.pdf

D.12 Guidance on the principles and best practice for the organisation and delivery of Audit and Risk Committees is available in the **Audit and Assurance Committee Handbook**[50] published by the Scottish Government.

D.13 It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.

D.14 The final component of the integrated governance system is the NHS Scotland Performance Management Framework. The following section of the supplementary guidance describes this arrangement in more detail.

50 **www.gov.scot/publications/audit-assurance-committee-handbook**

E. The NHS Scotland Performance Management Framework

E.1 As the sponsor of the NHS Boards, the Director General for Health and Social Care has put in place a performance management framework to assist the Scottish Government in ensuring that the NHS Boards are delivering services and targets to the required standards, within budgets and with the appropriate governance.

E.2 The NHS Scotland Performance Management Framework provides five stages of a Ladder of Escalation that provides a model for intervention by the Scottish Government when there are concerns about a NHS Board's ability to deliver the expected standards, targets and governance.

E.3 The model not only describes the stages of performance but also the level of support that would be provided by the Scottish Government Directorates for Health and Social Care at each stage.

Stage	Description	Response
1	Steady state 'on-plan' and normal reporting	Surveillance through published statistics and scheduled engagement of Annual Review and Mid-Year Reviews.
2	Some variation from plan; possible delivery risk if no action.	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring by Scottish Government. SG Directors aware.
3	Significant variation from plan; risks materialising; tailored support required.	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. DG aware.
4	Significant risks to delivery, quality, financial performance or safety; senior level external support required.	Transformation team reporting to Director General and CEO NHS Scotland.
5	Organisational structure/ configuration unable to deliver effective care.	Ministerial powers of Intervention.

E.4 The Ladder of Escalation's use is not limited to specific performance measures and may be triggered by concerns about specific services or broader organisational issues.

E.5 The Performance Management Framework is overseen by the National Planning and Performance Oversight Group, a sub-group of the Health and Social Care Management Board. The Oversight Group considers various forms of intelligence and makes subsequent recommendations to the Health and Social Care Management Board on escalation, de-escalation and/or the provision of enhanced support for NHS Boards.

ISBN: 978-1-80525-266-5

The Blueprint for Good Governance
Second Edition

November 2022

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Payroll Service Transfer to NSS Assurance Statement**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented to the Audit & Risk Committee for:

- Assurance

This report relates to:

- Local policy

This report aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

As of 1 February 2023, the NHS Fife Payroll process is now being provided by NSS and as such NHS Fife and the other partner boards have asked NSS to consider and provide suitable assurance for the continuity of the service to the Boards and their Auditors.

2.2 Background

In January 2023 the NHS Fife Board approved the Business Case to join the South East Payroll Consortium. The consortium consists of NHS Fife, Lothian, Forth Valley, SAAS, PHS, HIS, NES and NSS. NSS were selected to manage the consolidated Payroll Team.

Following the TUPE Transfer of the NHS Fife Payroll Team to NSS on 1 February 2023 it was agreed that a minimum six-month period of service stabilisation would be implemented before any service redesign would take place. This was agreed to minimise any short-term disruption encountered by the NHS Fife payroll team and reduce the risk of short-term failure.

This posed a challenge to NSS in that the payroll processes for NHS Fife and the six other boards who TUPE transferred to NSS would all continue to operate different payroll processes into 2023/24. A Service Audit is already provided to NHS Fife for IT Services and Practitioner and Counter Fraud Services by NSS, however to provide assurance to the partner boards on payroll services would not be feasible due to the significant differing working practices in each board.

The outline plan for the South East Payroll Consortium as documented in the Business Case was that the service redesign would take into account all aspects of the partner boards existing payroll process. A common 'best practice' approach would be designed and rolled out across all the existing teams leading to improved collaboration and potential efficiencies in the future whilst also ensuring that the most robust controls and operating procedures were implemented. This work will take place during 2023/24.

2.3 Assessment

The following Audit Plan (as per the attached timeline for the current Financial Year and the following two) has been proposed by NSS to give NHS Fife and the other partner Boards sufficient assurance that the payroll function(s) will continue to be appropriately monitored and controlled.

2022/23

1 – The NHS Fife external auditors will carry out controls testing based on months one to ten of this financial year. NSS will subsequently provide assurance that controls have not changed in the remaining two months of the year (post transfer to NSS).

2 – The NSS External Auditors may carry out additional substantive testing at the year end and the former NHS Fife payroll team will support this.

2023/24

1 – In Quarter one of 2023/24 (April – June) there will be an internal audit assignment carried out by NSS internal auditors KPMG of the existing NHS Fife and other partner boards payroll functions. It is anticipated that service redesign will commence in quarter two following the initial six-month service stabilisation period.

2 – In quarter four of 2023/24 PWC. NSS Service Auditors will carry out a Type 1 Service Audit which focuses on the test of design.

3 – All Payroll Teams will support External Audit testing as required.

2024/25

1 - PWC will carry out the full-service audit for NHS Fife and all South East Payroll Consortium partner Boards for the financial year,as per the existing arrangements for the IT Services and Practitioner and Counter Fraud Services provisions.

2 – All Payroll Teams will support External Audit testing as required.

This approach was agreed between both PWC and Audit Scotland and has been approved at the NSS Audit & Risk Committee. In addition Audit Scotland has communicated this approach to the other partner boards External Auditors at the February audit sector meeting. NHS Fife External Auditors, Azets have been made aware of this proposal and were in attendance.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

The NHS Payroll Function based on the 2021/22 encompassed salaries and wages for 14,088 individuals.

2.3.3 Financial

The continued oversight of the effective operation of the NHS Payroll function is a key element of financial control in NHS Fife. The Fife payroll function operating budget remains at c£0.5m..

2.3.4 Risk Assessment / Management

The proposed Audit plan by NSS provides assurance to NHS Fife that appropriate oversight and scrutiny will be applied to the payroll process going forward under the management of NSS.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Concerns around the need to provide NHS Fife with the appropriate level of assurance ahead of the 2022/23 Annual Accounts External Audit process was regularly discussed at the Programme Board meetings and the plan from NSS was formed after consultation with the NHS Fife Head of Financial Services & Procurement.

2.3.8 Route to the Meeting

The Audit & Risk Committee has been kept updated as the South East Payroll Consortium Business Case was both agreed and then subsequently implemented.

2.4 Recommendation

- **Assurance** – Members are asked to take assurance from the above Audit Plan proposed by NSS for 2022/23 and the following two years.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NSS South East Payroll Audit and Assurance Timeline.

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

SE Payroll Audit and Assurance

NHS National Services Scotland

74 staff TUPE into NSS 1 Feb 2023

Internal audit of the payroll functions in Q1
Type 1 Service Audit in Q4
Type 2 Service Audit for current NSS customers (NSS, PHS, HIS and NES)
External Audit testing as required

Type 2 Service Audit for the South East Payroll service.
External Audit testing as required

Boards' external auditors will do their controls testing based on month 1-10
Additional substantive testing at the year end supported by the payroll teams
Assurance from NSS that the controls and processes for each board have not changed in the period
Service audit continues for current NSS customers (NSS, PHS, HIS and NES)

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk - Director of Finance and Strategy**
Report Author:	**Pauline Cumming - Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Government policy/directive
- Local policy

This aligns to the following NHS Scotland quality ambition(s)

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is presented to the Committee to provide assurance on the management of the corporate risks. The paper provides:

- an updated summary of the current Strategic Risk Profile since the last report to the Committee on 5 December 2022;
- an overview of the current corporate risks

The Committee is invited to:

- Note the information provided;
- Consider the information against the Assurance Principles at Appendix 4;
- Conclude and comment on the assurance derived from the report

2.2 Background

The Corporate Risk Register aligns to the 4 strategic priorities. The format presents the corporate risks in a manner intended to prompt scrutiny and discussion around the level of assurance provided on the risks and their management, including:

- relevance
- proportionality
- reliability
- sufficiency

To ensure the Corporate Risk Register reflects and is sensitive to the internal and external environment, the content will be subject to regular review and scrutiny, including at the governance committees, to ensure:

- all relevant risks are identified;
- risks are clearly described in terms of cause and consequence;
- risks are scored appropriately;
- mitigating actions are SMART

2.3 Assessment

Since the last report to this Committee, the Corporate Risks have been reported to the governance committees in January 2023 and to the Board on 31 January 2023. Subsequently, the risks have been reviewed and updated by risk owners and are going through the third cycle of reporting to the governance committees during March 2023.

Members are asked to note the following updates:

STRATEGIC RISK PROFILE

- No risks have been closed.
- No new risks have been identified.
- Under *Strategic Priority: To Improve Health & Wellbeing* -
  1 risk - COVID 19 Pandemic - has reduced its current risk score (rating and level)

The overall Strategic Risk Profile has therefore reduced.

The Committee is asked to note that the majority of corporate risks (11) remain outwith risk appetite; this reflects the continued heightened risk profile during a period of ongoing operational challenges, and sustained system pressures. This position was highlighted to the Board on 31 January 2023, when they recognised this deviation from our stated risk appetite for elements of service quality, patient experience, staff health and wellbeing, and financial decision making, in order to support service delivery and workforce.

The Strategic Risk Profile and Risk Improvement Trajectory are provided at Appendix 1.

CORPORATE RISK REGISTER

As previously reported, the register contains 18 risks.

Risk Updates

In reviewing their risks, owners were asked to give particular attention to target risk scores to ensure these reflect the risk and the extent to which the target can be realistically achieved and / or mitigated in respect of risk reduction in the current financial year.

Members are asked to note the following specific changes to the risks:

Change to Risk Description

Risk 8 - Cancer Waiting Times: The risk description has been expanded to include the 31-day standard due to current removal of waiting times adjustments for social isolation and robotic prostatectomy, which is now a Fife service.

Changes to Current Risk Rating and / or Level

Reduced Risk

Risk 3 - COVID 19: In light of downward population numbers affected ,and the strong uptake of vaccination locally, the current risk rating and level have decreased from High 16 to Moderate 12; this means the risk has reached its target.

This risk continues to be monitored closely at local and national level as the pandemic remains a significant threat, with the situation remaining quite uncertain over the coming months; there are some signals about future variants which may cause a spike in March 2023, and could potentially increase the risk level again.

Changes to Target Risk Rating and /or Level

Increased Target

Risk 10 - Primary Care Services: Since the last report, the risk target has been revised up twice to more realistically reflect the risk and the extent to which it can be mitigated by year end. It has risen from Moderate 8 to High 16.

Risk 18 - Digital and Information: The risk target rating and level increased from Moderate 10 to High 15 in January 2023.

The Corporate Risk Register is provided at Appendix 3.

Deep Dive Reviews

For assurance purposes, it has been agreed that deep dive reviews will be prepared on the Corporate Risks aligned to each governance committee (or other risks as required).

To date, 8 of the 18 Corporate Risks have had deep dive reviews completed or planned for completion by the end of the March 2023 committee cycle. The Staff Governance Committee has commissioned reviews of non corporate risks which are otherwise aligned to staff governance.

The schedule of reviews for the remaining Corporate Risks is set out at Appendix 2.
Where necessary, the Lead Officers have been asked to agree a review schedule for the period 2023-2024, in consultation with Committee Chairs and members.

Next Steps

The Corporate Risk Register will continue to be updated between each committee cycle, through consideration of members' feedback, review at the Risks & Opportunities Group (ROG) and at the Executive Directors' Group (EDG).

This approach will support the further development of the Register, particularly in terms of monitoring and reviewing the risks, connecting to the Corporate Objectives, the Strategic Priorities and associated risk appetite, and to the operational risk profile.

There will be a continued focus on enhancing the content of risk reports, including the deep dive component, to ensure that it:

- explicitly links to the risk;
- is relevant;
- is based on reliable evidence; and
- is sufficient to allow an overt conclusion to be reached on the assurance provided

The ROG is currently considering the availability of data within Datix and is working on using this to support services to improve risk management performance, and to provide insight into the types or areas of emerging risk.

The ROG work plan for 2023-24 has allocated time to consider the emergence of risk, and the Group will review the developing Population Health and Wellbeing Strategy, and the outputs from the Strategic Planning and Resource Allocation Process (SPRA), to identify and recommend any changes or additions to the Corporate Risks.

2.3.1 Quality/ Patient Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities, to improve health and wellbeing and improve the quality of health and care services.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priority to improve staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

Effective management of financial risks will support delivery of our strategic priority to deliver value and sustainability.

2.3.4 Risk Assessment/Management

As outlined in this report.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to the Board. The outcome of that assessment concluded on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

This paper has been informed through engagement with stakeholders including:
Fife NHS Board on 31/01/23
Executive Directors' Group on 16/02/23
Public Health & Wellbeing Committee on 01/03/23
Clinical Governance Committee on 03/03/23
Staff Governance Committee on 09/03/23
Finance, Performance & Resources Committee on 14/03/23
Risks & Opportunities Group on 02/12/22 and 01/02/23

2.3.8 Route to the Meeting

Margo McGurk, Director of Finance & Strategy on 01/03/23

2.4 Recommendation

This paper is provided to the Committee for:

- **Assurance**

3 List of appendices

Appendix No. 1, Strategic Risk Profile and Risk Improvement Trajectory
Appendix No. 2, Deep Dive Review Schedule
Appendix No. 3, NHS Fife Corporate Risk Register as at 20/02/23
Appendix No. 4, Assurance Principles

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

Appendix 1

NHS Fife Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	▲	High
To improve the quality of health and care services	5	5	-	-	-	◀▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀▶	Moderate
Total	**18**	**13**	**5**	**0**	**0**		

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.

Mitigations in place to support management of risk over time with some risks requiring daily assessment.

Risk Improvement Trajectory for high risks and Corporate Risk Register assessment in place.

Risk Key	
High Risk	15 - 25
Moderate Risk	8 - 12
Low Risk	4 - 6
Very Low Risk	1 - 3

Movement Key	
▲	Improved - Risk Decreased
◀▶	No Change
▼	Deteriorated - Risk Increased

NHS Fife Risk Improvement Trajectory

To improve health and wellbeing	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	1*	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	2	2	-	-
Risks which have reached acceptable level of tolerance	-	1*	-	-
Total	**2**	**3**	**0**	**0**

1* risk has reduced from high to moderate level. In doing so, it reached its target.

To improve the quality of health and care services	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-

Risks which have deteriorated	-	-	-	-
Risks which have not moved	5	-	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**5**	**0**	**0**	**0**

To improve staff health and wellbeing	**Risk Improvement Trajectory**			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	2	-	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**2**	**0**	**0**	**0**

To deliver value and sustainability	**Risk Improvement Trajectory**			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	4	2	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**4**	**2**	**0**	**0**

Appendix 2

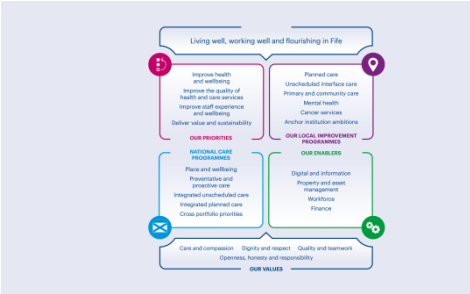
DEEP DIVE REVIEW SCHEDULE		
Risk Title	**Committee**	**Date**
Cancer Waiting Times (presented to both committees as originally aligned to CGC then changed to F,P&R)	CGC F,P&RC	04/11/22 15/11/22
Policy Obligations in relation to environmental management and climate change	PHWC	07/11/22
Cancer Waiting Times (for illustrative purposes)	SGC	10/11/22
Delivery of a balanced in-year financial position	F,P&RC	15/11/22
N/ A	PHWC	11/01/23
Nursing & Midwifery Staffing Levels (not corporate risk)	SGC	12/01/23
Digital & Information	CGC	13/01/23
Delivery of recurring financial balance over the medium term	F,P&RC(private session)	15/01/23
Health Inequalities	PHWC	01/03/23
COVID 19 Pandemic	CGC	03/03/23
Personal Development & Performance Review (not corporate risk)	SGC	09/03/23
Access to outpatient, diagnostic & treatment services	F, P&RC	14/03/23
Primary Care Services	PHWC	15/05/23
Population Health & Wellbeing Strategy	PHWC	TBC
Optimal Clinical Outcomes	CGC	TBC
Quality and Safety	CGC	TBC
Off Site Area Sterilisation & Disinfection Unit Service	CGC	TBC
Cyber Resilience	CGC	TBC
Workforce Planning & Delivery	SGC	TBC
Staff Health & Wellbeing	SGC	TBC
Whole System Capacity	F,P&RC	TBC
Prioritisation & Management of Capital Funding	F,P&RC	TBC

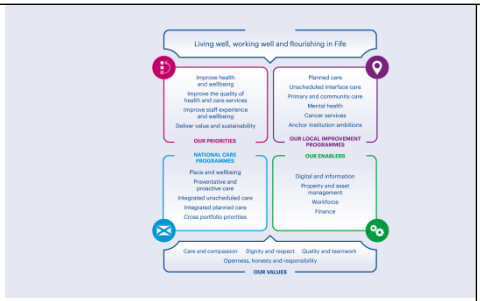
Clinical Governance Committee (CGC)
Finance, Performance & Resources (F, P&RC)
Staff Governance Committee (SGC)
Public Health & Wellbeing Committee (PHWC)

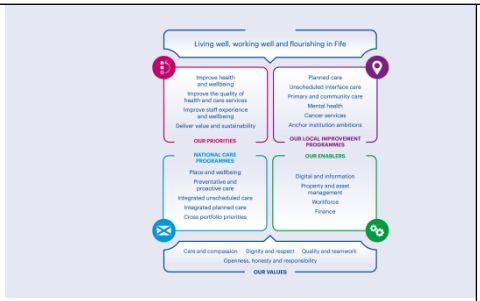
NHS Fife Corporate Risk Register as at 20/02/23

No	Strategic Priority	Risk	Mitigation	Risk Appetite High	Current Risk Level/ Rating	Target Risk by 31/03/23	Risk Level Trend	Risk Owner	Primary Committee
1		**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	EDG has established a Portfolio Board, reporting to the Public Health and Wellbeing Committee to deliver the required system leadership and executive support to enable effective strategy development. The Portfolio Board commissions and monitors the delivery of key milestone activity associated with the delivery of an effective new strategy.	Below	Mod 12	Mod 8	◄►	Chief Executive	Public Health & Wellbeing (PHWC)
2		**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. The future Population Health and Wellbeing Strategy will identify actions which will contribute to reducing health inequalities. Consideration of Health Inequalities within all Board and Committee papers. Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife. Deep dive into risk prepared for PHWC in March 2023.	Within	High 20	Mod 10	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

3		**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	The autumn/winter vaccination programme has had strong uptake, providing protection from more severe consequences of COVID19. Implementation of new treatments for individuals at higher risk of adverse outcomes. Current levels of infection are demonstrating a downward trend. Monitoring continues of possible new variants at national level. Tailored support continues to be provided to Care Homes with positive staff or resident cases Public communications programme to raise awareness of infection prevention and control measures across the region population cross the population. Deep dive being prepared for CGC in March 2023.	Below	Mod 12	Mod 12	▲	Director of Public Health	Clinical Governance (CGC)
4		**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements have been put in place including an Executive Lead and Board Champion appointed. Regional working group and representation on the National Board. Active participation in Plan 4 Fife. Develop draft NHS Fife Climate Emergency Report and Action Plan by end of January and June 2023 respectively. Draft sent to Scottish Government (SG). To go to EDG, Public Health & Wellbeing Committee and the Board in March 2023, before submission to SG. These will form part of the Annual Delivery Plan. Mechanics and	Below	Mod 12	Mod 10	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

			timescales still to be defined.						
5		**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	Within	High 15	Mod 10	◀▶	Medical Director	Clinical Governance (CGC)
No	**Strategic Priority**	**Risk**	**Mitigation**	**Risk Appetite** Moderate	**Current Risk Level/ Rating**	**Target Risk by 31/03/23**	**Risk Level Trend**	**Risk Owner**	**Primary Committee**
6		**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Integrated Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk.	Above	High 20	Mod 9	◀▶	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

									
7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by COVID -19 related disruption and stepping down of some non-urgent services, NHS Fife will see a deterioration in achieving waiting time standards. This time delay could impact clinical outcomes for the population of Fife.	Recovery Plans developed outlining additional activity and resources required to reduce backlog and meet ongoing demand. Confirmed funding less than anticipated. A further plan submitted in December supported by additional funding until the end of March 2023 has been agreed and implemented to reduce numbers of long waiting patients. Planning for 2023/24 underway in line with planning guidance letter received on 06/02/23. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. Deep dive of this risk is being prepared for F, P&R in March 2023.	Above	High 16	Mod 12	◀▶	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

									
8		**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	Weekly meetings with Scottish Government (SG) and monthly monitoring of the Effective Cancer Management Framework continue. SG will attend the Acute Cancer Services Delivery Group in May 2023. Additional resource to support daily tracking will cease from March 23. A national 'Once for Scotland' Effective Breach Analysis (EBA) was launched in January 2023. NHS Fife are taking steps to implement and areas of non-compliance have been identified. The Single Point of Contact Hub was launched (SPOCH) on 1/9/22; a 6 month review will determine if there has been a reduction in DNAs; this will be carried out at end of February 2023. Patient and staff evaluation questionnaire exercise will be done along with an exercise to assess reduction in patient calls to Clinical Nurse Specialist (CNS). Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. An update on 2022-23 actions has been done and actions for 2023-24 identified.	Above	High 15	Mod 12	◀▶	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			The Cancer Framework and delivery plan has been signed off by governance groups, and Clinical Governance Committee and is due to be signed off by the NHS Board in March 2023. Implementation of the optimal pathway for Lung cancer has commenced and pathway improvement project for prostate cancer. A deep dive into urology performance challenges is being undertaken. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.						
9		**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee(CGC). This is further supported by the Organisational Learning Group to ensure that learning is used to optimise patient safety, outcomes and experience, and to enhance staff wellbeing and job satisfaction. There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact.	Above	High 15	Mod 10	◀ ▶	Medical Director	Clinical Governance (CGC)

10		**Primary Care Services** There is a risk that due to a combination of the demand on services, workforce availability and current funding and resourcing of Primary Care, it may not be possible to deliver sustainable quality services to the population of Fife into the medium-term.	A Primary Care Governance and Strategy Oversight Group is in place. The group, co-chaired by the Medical Director and the Director of Health and Social Care, brings together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of governance. It provides assurance to NHS Fife Board and the Integration Joint Board (IJB) through the appropriate sub committees. This group allows governance and scrutiny of all aspects of primary care delivery and provides a focus for improving patient care for the population of Fife. A Primary Care Strategy is in development and is at final draft stage; it will be presented to commissioners for discussion and support February 2023 then via committees for approval by April 2023. A Primary Care Improvement Plan (PCIP) in place; subject to regular monitoring and reporting to General Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB and Scottish Government. A workshop took place in January 2023 to review and refresh the current PCIP to ensure it is contemporary and based on current position and known risks to ensure a realistic and feasible PCIP. This will be progressed via committees for approval and move to implementation in April 2023. A review of models of care incorporating the learning from the	Above	High 16	High 16▼ (12 by 2024 (8 possible by 2025)	◄►	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			pandemic is continuing alongside a review of leadership, management and governance structure which has been jointly commissioned by Deputy Medical Director (DMD) and Head of Service(HOS) for P&PC with recommendations expected in March 2023 Remodelling and recruitment of workforce action plan resulting from earlier Committee report will be completed as part of the refreshed PCIP Memorandum of Understanding 2 - (Pharmacotherapy, Community Treatment and Care (CTAC) Network and Vaccine Programme) action plan to deliver by September 2022 - Vaccine Programme is COMPLETE. Pharmacotherapy and CTAC models for care continue to be shaped and developed. The anticipated date for completion is April 2024. A deep dive review will be prepared for PHWC in May 2023.						
No	**Strategic Priority**	**Risk**	**Mitigation**	**Risk Appetite** Moderate	**Current Risk Level/ Rating**	**Target Risk by 31/03/23**	**Risk Level Trend**	**Risk Owner**	**Primary Committee**
11		**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.	Continued development of the workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025 and aligned service based workforce plans. Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health &	Above	High 16	Mod 8	◄►	Director of Workforce	Staff Governance (SGC)

			Social Care Strategic Plan for 2019 to 2022 and the integration agenda. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours and aligned to the ambitions of an anchor institution.						
12		**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, was published in December 2022.	Above	High 16	Mod 8	◄►	Director of Workforce	Staff Governance (SGC)
No	**Strategic Priority**	**Risk**	**Mitigation**	**Risk Appetite** Moderate	**Current Risk Level/ Rating**	**Target Risk by 31/03/23**	**Risk Level Trend**	**Risk Owner**	**Primary Committee**
13		**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board may not achieve its statutory financial targets in 2022/23 without additional support from Scottish Government.	Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation.	Above	High 16	Mod 12	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)
14		**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions	Strategic Planning and Resource Allocation process will continue to operate and support financial planning. The FIS Programme will focus on medium-term productive opportunities and cash releasing savings.	Above	High 16	Mod 12	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

		required to ensure sustainable financial balance over the medium-term.	The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term.						
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Infrastructure developments prioritised and funded through the NHS Board capital plan. Annual Property and Asset Management Strategy (PAMS) report submitted to F, P&R, NHS Board and Government. Well attended Fife Capital Investment Group (FCIG) workshop held in January 2023 to discuss and agree Capital Priorities for future years. Papers will go to FCIG in March 2023.	Within	Mod 12	Mod 8	◀▶	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)
16		**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review through Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) have agreed the design and the unit at St Andrews Community Hospital (SACH) should be operational by June 2023.	Within	Mod 12	Low 6	◀▶	Director of Property & Asset Management	Clinical Governance (CGC)
17		**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	Considerable focus continues in 2023 with heightened threat level to improve our resilience to attack and ability to recover quickly. The primary mechanism for prioritising items is the response to the Network Information Systems Directive (NISD) review report May 2022.	Above	High 16	Mod 12	◀▶	Medical Director	Clinical Governance (CGC)

18		**Digital & Information** There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy. Digital & Information Board Governance established and supporting prioritisation with ongoing review.	Above	High 15	High 15	◀▶	Medical Director	Clinical Governance (CGC)

Risk Movement Key

▲ Improved - Risk Decreased
◀▶ No Change
▼ Deteriorated - Risk Increased

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda items should relate to risk (where relevant)

Seek Assurance on Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or – Escalation / Recording
- Scrutiny of risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

GENERAL QUESTIONS:

- Does the risk description fully explain the nature and impact of the risk?
- Do the current controls match the stated risk?
- How weak or strong are the controls? Are they both well-designed and effective i.e. implemented properly
- Will further actions bring the risk down to the planned / target level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and explicitly link to the strategic priorities and objectives / corporate risk?

SPECIFIC QUESTIONS WHEN ANALYSING A RISK DELEGATED TO THE COMMITTEE IN DETAIL:

- History of the risk (when was risk opened); has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances - which monitor the application of controls/actions?
- Assessing Controls
  - Are they 'Key' i.e. are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty :
  - Are they are on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management / performance / data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports / external assessments?

LEVEL OF ASSURANCE

Substantial Assurance	Adequate Assurance	Limited Assurance
Controls are applied continuously with minor lapse	Controls are applied with some lapses	Significant breakdown in the application of controls

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Internal Audit Framework**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This report is presented to the Audit & Risk Committee for:

- Decision

This report relates to:

- Legal requirement
- Local policy

This report aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter, that defines Internal Audits purpose authority and responsibility, whilst also clarifying the functional reporting relationships and accessibility provisions. This Charter, part of the Internal Audit Framework is to be annually reviewed and updated following approval by the Board, in this case through the Audit and Risk Committee.

The Charter is complementary to the relevant provisions included in the Board's Standing Orders and Standing Financial Instructions and the Shared Service Agreement and Service Specification with FTF Audit.

2.2 Background

Internal Audit is an independent, objective assurance and consulting function designed to add value and improve the operations of NHS Fife. Internal Audit supports NHS Fife to accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes.

Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit and Risk Committee on the overall adequacy and effectiveness of NHS Fife's framework of governance, risk management

and control. In addition, internal audits findings and recommendations are beneficial to management in securing improvement in the audited areas.

FTF Audit provides the internal audit service as part of a shared service which is hosted by NHS Fife. A partnership Board comprising of the Directors of Finance for NHS Fife, Forth Valley and Tayside is chaired by the Director of Finance of NHS Tayside. The FTF Partnership board have the responsibility to approve the draft Internal Audit Framework prior to the presentation to the respective boards' Audit and Risk Committees for their final approval.

2.3 Assessment

The attached internal audit framework sets out the Audit Charter, Service Specification and Reporting Protocol that have been reviewed and provided to NHS Fife for 2023/24. The revised framework follows on from the 2022/23 internal audit framework which was previously approved at the meeting of the Audit and Risk Committee on 18th May 2022. There are no material changes but it is important that the Audit and Risk Committee is assured that the document has been reviewed and has the opportunity to comment.

The Internal Audit Framework has been approved by the FTF Partnership Board members and is now presented to the Audit & Risk Committee for its formal approval.

2.3.1 Quality / Patient Care

Internal Audit's Mission statement provides that 'Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve the organisations operations'.

2.3.2 Workforce

Due consideration is given to the appropriate staff skill mix and is provided in the service specification.

2.3.3 Financial

Any identified Financial Implications will be highlighted to the appropriate responsible individual within NHS Fife.

2.3.4 Risk Assessment / Management

Internal Audit assignments identify the key risks at the planning stage and the work is designed to evaluate whether appropriate control systems are in place and are operating effectively to mitigate the risks identified at the onset.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

Any Internal Audit assignments which involve the review of policies and procedures will consider the way in which equality and diversity is incorporated into the Boards documentation.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

All elements of this framework have been produced by Internal Audit and shared with the Director of Finance and Strategy

2.3.8 Route to the Meeting

This framework has been produced by the Chief Internal Auditor and Regional Audit Manager.

The Internal Audit Framework was approved by the FTF Partnership Board on 1 November 2022.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- Note the NHS Fife Specification for Internal Audit Services
- Decision - Approve the Internal Audit Charter
- Decision - Approve the NHS Fife Internal Audit Reporting Protocol and Audit Follow Up Protocol

3 List of appendices

The following appendices are included with this report:

- Appendix A, Internal Audit Framework

Report Contact
Tony Gaskin
Chief Internal Auditor
Email tony.gaskin@nhs.scot

Introduction

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter which is regularly updated following approval by the Board, in this case through the Audit and Risk Committee. This Charter is complementary to the relevant provisions included in the organisation's own Standing Orders (SOs) and Standing Financial Instructions (SFIs) and the Shared Service Agreement and Service Specification with FTF Audit (SSA).

The terms 'Board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of NHS Fife with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit and Risk Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for NHS Fife. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Finance and Strategy.
- FTF are the Internal Auditors for NHS Fife.

Purpose and responsibility

"Internal audit is an independent, objective assurance and consulting function designed to add value and improve the operations of NHS Fife. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes." Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight. (See Appendix 1 for FTF Mission Statement).

Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit and Risk Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

The Shared Services Agreement and associated Service Specification with FTF set out their specific responsibilities as internal auditors to NHS Fife.

Independence and Objectivity

Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Chief Internal Auditor will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit and Risk Committee and Accountable Officer.

Organisational independence is effectively achieved when the auditor reports functionally to the Audit and Risk Committee on behalf of the Board. Such functional reporting includes the Audit and Risk Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be subject to Internal Audit.

This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision across FTF provides further organisational independence.

The Shared Services Agreement sets out the operational independence of FTF as internal auditors to NHS Fife. In particular it states '*FTF may be called upon to provide advice on controls and related matters, subject to the need to maintain objectivity and to consider resource constraints. Normally FTF will have no executive role nor will it have any responsibility for the development, implementation or operation of systems. Any internal audit input to systems development work will be undertaken as specific assignments. In order to preserve independence and objectivity, any such involvement in systems development activities will be restricted to the provision of advice and ensuring key areas in respect of control are addressed*.'

FTF have controls in place to ensure compliance with the relevant aspects of the Public Sector Internal Audit Standards and the wider requirement to conform with NHSScotland standards of conduct regulations.

Appointment of CIA and Internal Audit Staff, Professionalism, Skills & Experience

Under s5.1 of the Specification, NHS Fife as the host body, is responsible for appointing a CIA who (Spec s12.6) is a member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and at least three years of audit.

The Specification also sets out the required qualified skill-mix and the proportion of the Audit Plan to be delivered by the Chief Internal Auditor, Regional Audit Managers and other qualified staff as well as specifying the responsibility of FTF to ensure staff are suitably trained with appropriate skills with a formal requirement for preparation and maintenance of Personal Development Plans for all audit staff.

Authority and Accountability

Internal Audit derives its authority from the NHS Board, the Accountable Officer and Audit and Risk Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

The Chief Internal Auditor leads FTF and assigns a named contact to NHS Fife. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Regional Audit Managers report to the Chief Internal Auditor.

The Chief Internal Auditor reports on a functional basis to the Accountable Officer and to the Audit and Risk Committee on behalf of the Board. Accordingly the Chief Internal Auditor has a direct right of access to the Accountable Officer, the Chair of the Audit and Risk Committee and the Chair of the Health Board if deemed necessary.

The Audit and Risk Committee approves all Internal Audit plans and may review any aspect of its work. The Audit and Risk Committee also has regular private meetings with the Chief Internal Auditor and its remit requires it '*To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors'.*

In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

Relationships

The Chief Internal Auditor will maintain functional liaison to the Director of Finance and Strategy who has been nominated by the Accountable Officer as executive lead for internal audit.

In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with NHS Fife Executive Directors Group in planning its work programme. Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

The Audit and Risk Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit and Risk Committee will remain the final reporting line for all reports.

Standards, Ethics, and Performance

Internal Audit must comply with the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards and the Definition of Internal Auditing. The CIA will discuss the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework with senior management and the Board.

Internal Audit will operate in accordance with the Shared Services Agreement (updated 2019) and associated performance standards agreed with the Audit and Risk Committee. The Shared Services Agreement includes a number of Key Performance Indicators and we have agreed with the Audit and Risk Committee that these will be reported to each Audit and Risk Committee meeting as part of the Internal Audit Progress report.

Scope

The scope of Internal Audit within the organisations clinical and non – clinical environment encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- Reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- Reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;

- Reviewing specific operations at the request of the Audit and Risk Committee or management, this may include areas of concern identified in the corporate risk register;
- Monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance (see below);
- Ensuring effective co-ordination, as appropriate, with external auditors; and
- Reviewing Annual Governance Statement prepared by senior management.

Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

If the Chief Internal Auditor or the Audit and Risk Committee consider that the level of audit resources or the Charter in any way limit the scope of Internal Audit, or prejudice the ability of Internal Audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

Risk Management

Internal Audit will liaise with both the Audit and Risk Committee and senior management to discuss the alignment of audit priorities to strategic and emerging risks. This will include the strategic risks not being audited in-year to enable a discussion about coverage and the level of audit resource.

Each year an annual overview of risk management arrangements will be undertaken by FTF through the Internal Control Evaluation and Annual Report.

An overall review of risk management has been included within the annual internal audit plan. This review will encompass validation of risk management group assurances, risk management self-assessments and KPI reporting.

We will also review the risk management systems, associated controls, assurance processes and functions, and test the operation of controls beyond the risk register within NHS Fife. This will be achieved through specific audits and by incorporation within standard audit processes as part of every relevant audit undertaken. Significant findings will be communicated to allow immediate action to be taken by NHS Fife.

Appropriate communication is in place with the risk management function which includes provision of all audit reports and regular meetings with risk management managers.

Reporting arrangements including Key Performance Indicators

Arrangements for reporting and following up individual assignments are contained within the reporting and follow-up protocols approved by the Audit and Risk Committee. The Specification states that '*The principal report to be produced by Internal Audit will be the Annual Audit Report for each audit year. This needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I in order to provide the assurance required in considering the Board's Annual Accounts.*

The Annual Audit Report should contain:

- *An opinion on whether:*
  - ✧ *Based on the work undertaken, there were adequate and effective internal controls in place throughout the year;*
  - ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
  - ✧ *The Internal Audit plan has been delivered in line with PSIAS*
- *analysis of any changes in control requirements during the year*
- *comment on the key elements of the control environment*

- *summary of performance against this service specification*
- *progress in delivering the Quality Assurance Improvement Programme.*

The Specification sets out the key performance indicators to be used by Internal Audit and requires that they be reported in full within the Annual Internal Audit Report and they are also reported to the Audit and Risk Committee at each meeting as part of the Internal Audit Progress report.

Assurances provided to parties outside the organisation;

Internal Audit will not provide assurance on activities undertaken by NHS Fife to outside parties without specific instruction from NHS Fife or as per the approved output sharing protocol.

Approach

To ensure delivery of its scope and objectives in accordance with the Charter, Internal Audit has produced a suite of working practice documents. This includes arrangements for annual and strategic planning, individual audit assignment planning, fieldwork and reporting.

Access and Confidentiality

Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation. NHS Fife's Standing Financial Instructions state that '*The Chief Internal Auditor is entitled without necessarily giving prior notice to require and receive:*

a) *Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.*

b) *Access at all reasonable times to any land, premises or employees of the Board;*

c) *The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and*

d) *Explanations concerning any matter under investigation.*

All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. S6.6 of the SSA sets out those circumstances in which reports and working papers will be shared with the statutory External Auditors and the application of the Freedom of Information (Scotland) Act 2002.

Where there is a request to share information amongst the NHS bodies, for example to promote good practice and learning, then permission will be sought from the Accountable Officer/Lead Officer before any information is shared.

Irregularities, Fraud & Corruption

It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Fraud Liaison Officer in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and with S10 of the SSA.

Quality Assurance

S7 of the Specification requires that '*the Chief Internal Auditor shall be responsible for the preparation and maintenance of quality processes which maintain and record the operational procedures and quality standards of the Service, and which are compliant with PSIAS*.'

The Chief Internal Auditor has established a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against PSIAS and against agreed KPIs will be provided in the Annual Internal Audit Report. KPIs will also be reported to each Audit and Risk Committee meeting as part of the Internal Audit Progress Report.

Resolving Concerns

S5.2 of the Specification states that '*The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance and Strategy whenever required and at least bi-annually to discuss the service*.' S7 of the SSA states that '*The Chief Internal Auditor shall be available to meet with the Client Director of Finance or nominated representative whenever required and at least bi-annually to discuss the services. Any issues should be raised with the Chief Internal Auditor in the first instance.*

If the matter is not resolved to the satisfaction of the Client, then it shall be presented to the next available meeting of the Partnership Board for resolution by majority vote.'

Review of the Internal Audit Charter

This Internal Audit Charter shall be reviewed annually and approved by the Audit and Risk Committee.

Date: March 2023

Date of next review: March 2024

Mission and values

The purpose of the internal audit function has been defined within the Public Sector Internal Audit Standards (PSIAS). FTF, following discussion with staff and the Partnership Board has developed a mission and vision statement which incorporates this definition as well as additional elements reflecting our way of delivering the audit function as follows:

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

We achieve this by following the Public Sector Internal Audit Standards:

*"Internal Audit is an independent, objective **assurance** and consulting activity designed to **add value** and **improve** an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes".*

We work with our clients to provide an excellent service by understanding their values, their objectives and risks and the environment in which they operate. We value and listen to our staff and ensure that they have the skills and knowledge they require to help us to succeed, continuously assessing and improving the service we provide.

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

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1. Introduction

This document sets out a specification for the Internal Audit requirements of the Client. The specification is for a total Internal Audit Service to the Client organisation over the period 1 April 2019 to 31 March 2024.

Wherever reference is made to Audit and Risk Committee, Director of Finance etc. it shall refer to that of the Client unless otherwise specified.

1.1 FTF will undertake to perform the Internal Audit Service in accordance with the provisions set out in this specification.

1.2 Either party shall be entitled to terminate the Agreement for the Internal Audit Service. Prior to the termination of the Agreement both parties must follow any agreed management arrangements relating to termination. These arrangements will be agreed prior to the start of the Agreement and will include the period of notice to be given.

1.3 In addition to the obligations imposed within this specification, it is the duty of FTF to provide the Internal Audit Service to a standard that is in all respects acceptable to the Director of Finance and the Audit and Risk Committee and consistent with professional standards and complies with the Internal Audit Charter approved by Audit & Risk Committee annually.

1.4 FTF and its staff must respect all medical and managerial confidences and shall regard as confidential and shall not disclose, except as required by law, to any person other than a person authorised by the Client, any information acquired by FTF or its staff in connection with the provision of the Internal Audit Service concerning:

- ✧ the organisation or its directors and officers;
- ✧ patient identity;
- ✧ medical condition of/treatment received by patients

1.5 Subject to the availability of resources, FTF and its staff shall co-operate and respond to reasonable requests or give support in situations, whether or not they are detailed in the specification.

1.6 FTF shall comply with any relevant directives issued by the Scottish Government Health and Social Care Directorates, including the Public Sector Internal Audit Standards.

2. Internal Audit Responsibilities

2.1 Within the organisation, responsibility for internal control rests fully with management to ensure that appropriate and adequate arrangements are established. FTF will be responsible for conducting an independent appraisal and giving assurance to the Audit and Risk Committee on all internal control arrangements.

2.2 FTF will be responsible for obtaining relevant, reliable and sufficient audit evidence in order to provide an opinion to the client on the adequacy and effectiveness of internal controls. FTF will also assist management by evaluating and reporting to them on the effectiveness of the controls for which management are responsible.

2.3 FTF will consider the adequacy of controls necessary to secure propriety, economy, efficiency and effectiveness in all areas and will seek to confirm that management have taken the necessary steps to achieve these objectives.

2.4 In order to provide the required assurance, FTF will evaluate the controls that management have established to ensure that:

- ✧ the organisation's objectives are achieved
- ✧ there is economical and efficient use of resources
- ✧ risks are adequately and effectively identified, recorded and managed

- ✧ there is compliance with established policies, procedures, laws and regulations
- ✧ assets belonging or entrusted to the organisation are properly controlled and safeguarded from losses of all kinds, including those arising from fraud, irregularity or corruption
- ✧ there is integrity and reliability of information and data provided to management including that used in decision making
- ✧ the organisation's interests are protected with regard to any contractual arrangements entered into
- ✧ the controls over information technology applications and installations are sufficient in quality and comply with recommended standards

2.5 FTF may be called upon to provide advice on controls and related matters, subject to the need to maintain objectivity and to consider resource constraints. Normally FTF will have no executive role nor will it have any responsibility for the development, implementation or operation of systems. Any internal audit input to systems development work will be undertaken as specific assignments. In order to preserve independence and objectivity, any such involvement in systems development activities will be restricted to the provision of advice and ensuring key areas in respect of control and risk are addressed.

2.6 It will not be within FTF's remit to question the appropriateness of policy decisions. However, FTF may draw to the attention of the Audit & Risk Committee instances where there are illegal acts or contraventions of Standing Orders, Standing Financial Instructions or Statutory Powers and Regulations. FTF may also examine the management arrangements for making, monitoring and reviewing all such policy decisions.

3. Internal Audit Standards

3.1 Public Sector Internal Audit Standards (PSIAS)

3.2 FTF shall comply with PSIAS and report on its compliance to the Audit and Risk Committee as part of the Annual Internal Audit Report. FTF shall maintain a system to ensure compliance with Public Sector Internal Audit Standards and shall adhere to an agreed timetable for external quality assessments and reporting on a formal mid-point self-assessment against the Standards.

4. Planning

4.1 At the start of the calendar year, the Audit and Risk Committee and senior management team shall consider the findings of the Internal Audit Internal Control Evaluation together with the Strategic Risk Register and advise Internal Audit of key topics they wish to be considered for inclusion in the Internal Audit Plan for the following financial year.

4.2 Internal Audit shall then prepare a strategic and operational audit plan based on the Strategic Risk Register and independent assurances available from other sources. In order to ensure coverage of all key controls, the plan also takes into account the Internal Audit risk assessment, which shall be reviewed annually and updated for changes in systems, in organisation and in the NHS control framework.

4.3 Audit plans based on these factors will then be prepared by FTF, agreed with the Director of Finance and discussed with the external auditors prior to submission to the Senior Management Team and then the Audit and Risk Committee. They will comprise a Strategic Audit Plan and an Annual Audit Plan in a format agreed with the Audit and Risk Committee.

4.4 The Strategic Audit Plan and Annual Audit Plan should separately identify any special investigations and should also include a provision for contingencies.

Strategic Audit Plan

4.5 The Strategic Audit Plan should cover the period of appointment during which all major risks, systems and key areas of activity, identified by the planning process, will be audited. The plan should usually incorporate a rotation of audit emphasis to form a cyclical approach.

There are a number of areas within the audit universe which, because of their nature, need to be planned for outwith the Risk Assessment process. These may include:

- ✧ Core Financial systems where assurance is required by External Audit
- ✧ Reviews targeting high risk fraud/probity areas through proactive CFS liaison
- ✧ Management of significant projects
- ✧ Post-transaction Monitoring.

The Strategic Plan should set out the audit areas categorised by type of activity, risk rating, frequency of audit, and an assessment of resources to be applied. It should be prepared in conjunction with Audit and Risk Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by 30 June. The Strategic Plan should be updated annually in order to inform the Annual Audit Plan.

Annual Audit Plan

4.6 The Chief Internal Auditor in each year of the Agreement shall submit to the Audit and Risk Committee an Annual Audit Plan, which should reflect the audit coverage identified in the Strategic Audit Plan. Each Annual Audit Plan should cover the next twelve month period (May-April) and should be submitted to the Senior Management team and Audit and Risk Committee by no later than 30 June, subject to timely receipt of the appropriate risk assessment scoring template from the Client or by agreement with the Client. The Annual Audit Plan should set out the planned scope of audit work and should identify the critical areas to be covered and resources required in each project.

Audit Assignment Plans

4.7 An audit work schedule should be produced for each audit project undertaken and agreed with the relevant Director and Director of Finance. The assignment plans will identify the following:

- ✧ Job number and title
- ✧ Relevant Corporate/operational risks
- ✧ Relevant Director and responding officer
- ✧ Audit staff
- ✧ Start date and planned number of audit days required
- ✧ Scope, control objectives and other instructions
- ✧ Target draft report date and target Audit & Risk Committee.

5. Managing Audit Work

5.1 Fife NHS Board shall appoint a person to be the Chief Internal Auditor. The Chief Internal Auditor will be responsible for managing and undertaking specified audit tasks to appropriate quality and other work standards. This includes management of internal audit staff and resources. The tasks will be based on the Annual Audit Plan approved by the Client Audit and Risk Committee along with any additional items covered by the contingency provision. That Committee will consider any significant changes to the scope or duration of assignments.

5.2 The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service.

5.3 The Regional Audit Manager will be expected to be available to attend meetings with the Director of Finance at least monthly and as required, to discuss the progress of individual projects. The Regional Audit Manager will be the Internal Audit point of contact for any other bodies, internal or external, such as the external auditor.

5.4 The Audit and Risk Committee and Director of Finance must endeavour to ensure management's perspective of internal audit is positive and that a participative approach is adopted. Therefore FTF will be expected to actively involve and keep auditees informed during all stages of audit assignments. This is particularly crucial during the testing and evaluation stages when it would be more appropriate to inform management of the emerging findings where these are significant rather than wait and produce the findings in a report at a later date. The circumstances where this approach would be appropriate would be:

- ✧ where there may be a material loss to the organisation unless action is taken quickly
- ✧ where there is a serious breach of law/regulations

There will be occasions when this approach is not however appropriate (i.e. where fraud or irregularities are suspected) and involvement of the Director of Finance must be sought (see s11).

5.5 The Chief Internal Auditor is responsible for delivering an economic and efficient quality audit and ensuring that the internal audit service is delivered according to the terms of this specification. The Chief Internal Auditor also has a responsibility to the Audit and Risk Committee, Chief Executive and Director of Finance. Broadly this encompasses the following areas:

- ✧ Planning logical and comprehensive coverage that reflects the agreed degree of risk associated with each system
- ✧ Identifying and selecting resources and funding
- ✧ Determining standards
- ✧ Monitoring delivery and quality assuring the products including compliance with Public Sector Internal Audit Standards
- ✧ Effecting appropriate changes
- ✧ Promoting the work of Internal Audit and the Audit & Risk Committee as a contribution to the control environment within the organisation
- ✧ Audit reporting
- ✧ Attendance at Audit and Risk Committees as appropriate and to present the Strategic Plan, Interim review and Annual report
- ✧ Promoting the Internal Audit Service to members and officers
- ✧ Managing requests for unplanned work.

5.6 In addition the Chief Internal Auditor will have managerial and personnel responsibilities for Internal Audit staff.

6. Reporting

6.1 The main purpose of Internal Audit reports is to provide management and the Audit and Risk Committee with information on significant audit findings, conclusions and recommendations. For full Internal Audit reviews of systems carried out as part of the identified Annual Audit Plan, Internal Audit will provide an opinion on the adequacy of internal controls within the system, except where specified within the reporting protocol e.g. Financial Process Compliance, or reviews of known areas of weakness as requested by management etc.

6.2 The aim of every internal report should be to:

- ✧ define the scope and objectives of the work carried out
- ✧ provide a formal record of issues and recommendations arising from the internal audit assignments and, where appropriate, of agreements reached with management
- ✧ instigate management action to improve performance and control

6.3 In addition, Internal Audit should provide the Director of Finance and Audit and Risk Committee with regular reports on progress (see 0 below).

6.4 The Audit and Risk Committee should approve a formal follow-up protocol for ensuring that agreed Internal Audit recommendations have been actioned. This is incorporated as Appendix III to this Specification.

6.5 The Chief Internal Auditor should ensure that reports are sent to managers who have a direct responsibility for the activity being audited and who have the authority to take action on the subsequent internal audit recommendations.

6.6 The distribution of reports by Internal Audit should be restricted to those individuals who need the information including members of the Audit and Risk Committee and the appointed external auditors. Except as required by law or as agreed within an approved output sharing protocol with IJB partners, documents should not be divulged to any other third party without the written express permission of the Director of Finance and/or Audit and Risk Committee.

Individual Audit Project Reporting

6.7 For each audit project, the Internal Auditor shall prepare and submit a draft report of findings in a form agreed by the Audit and Risk Committee and Director of Finance. The reporting protocol shall be approved by the Audit and Risk Committee and incorporated as Appendix II to this document and shall include target timescales for issue and responding to Internal Audit reports.

It is expected that where it is necessary to alert management to the need to take immediate action to correct a serious weakness in performance or control or where material errors or irregularities are identified, these will immediately be brought to the attention of the Director of Finance and if appropriate the Chair of the Audit and Risk Committee.

Annual Audit Reporting

6.8 The principal reports to be produced by Internal Audit will be the Internal Control Evaluation (ICE) and the Annual Internal Audit Report for each audit year. The ICE is normally presented to the January Audit and Risk Committee and the Annual Internal Audit Report needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

- ✧ An opinion on whether:
  - ✧ Based on the work undertaken, there were adequate and effective internal controls in place throughout the year

- ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- ✧ The Internal Audit plan has been delivered in line with PSIAS
- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Programme.

The summary of performance will include details of staffing and skill mix in addition to the other performance measures outlined in Appendix I

In addition to the Annual Internal Audit Report, other reports may require to be made to the Audit and Risk Committee as requested by the Director of Finance.

Progress reporting

6.9 The Director of Finance will receive regular reports, together with the FTF Balanced Scorecard specific to the client, on dates specified by the Client, detailing progress against the agreed Annual Audit Plan together with notification of any significant breaches of the timescales within the approved reporting protocol.

For each individual assignment within the plan the following will be reported:

- ✧ Planned days
- ✧ Actual days to date
- ✧ Planned start date
- ✧ Date of each milestone
- ✧ Audit opinion (where applicable)

Progress reports will also be presented to each Audit and Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

7.1 The Chief Internal Auditor will be held accountable by the Audit and Risk Committee for performance and is therefore responsible for ensuring quality standards are defined, agreed, monitored and reported. These aspects of quality should be enshrined in the Performance Measures, shown in Appendix 1 and reported within the Annual Internal Audit Report.

7.2 The Chief Internal Auditor shall continuously review the performance of each region and use this review to inform the bi-annual discussion with the Client Director of Finance.

7.3 The Chief Internal Auditor shall be responsible for the preparation and maintenance of quality processes which maintain and record the operational procedures and quality standards of the Service and which are compliant with PSIAS.

7.4 FTF shall report compliance with the PSIAS within the Annual Internal Audit Report, including the outcomes of any External Quality Assessments and progress in implementing any required actions. See also the provisions in 3.1 above.

Client Satisfaction Survey

7.5 A questionnaire will be issued to key contacts at the end of each audit review in a format agreed with the Director of Finance. The Chief Internal Auditor shall review these surveys, investigate any matters of concern and take appropriate remedial action where required. The results of the surveys should be reported annually to the Audit and Risk Committee within the Annual Internal Audit Report.

7.6 In addition, the Chief Internal Auditor will seek to ascertain the views of the Audit and Risk Committee and Board Members in relation to the quality of the service. This will be achieved through discussion with the Director of Finance, and through the offer of availability for meetings with the Audit and Risk Committee Chair and Board Chair.

8. Liaison with External Audit

8.1 The Public Finance and Accountability (Scotland) Act, provides for the accounts of Health Bodies to be audited by auditors appointed by Audit Scotland.

8.2 FTF will be expected to maintain a close working relationship with the Statutory Auditors on matters of mutual interest and to provide them with copies of all formal internal audit reports. The Statutory Auditor will be allowed access on request to all internal audit working papers and Final and Draft Final reports.

9. Best Value Reviews

9.1 It is the responsibility of the Internal Auditor, as part of the general review of systems of internal control, to review, appraise and report to management the extent to which the organisation's assets and interests are accounted for and safeguarded against losses of all kinds arising from fraud and other offences, waste, extravagance and inefficient administration, poor value for money or other cause.

9.2 This shall be achieved by the inclusion within the audit universe, and therefore the Strategic Audit Plan, of those systems of service monitoring and performance measurement that are critical for the attainment of value for money including the framework for providing overt assurance to the Accountable Officer on Best Value.

10. Suspected Criminal Offences

10.1 CEL (2013)11, an update of CEL (2008) 03 “Strategy to Combat Financial Crime in NHS Scotland” sets out further requirements on Boards and the requirements of the Bribery Act (2010) need to be met. Whilst the key messages from CEL 11 (2013) remain relevant, the annual list of activities required by NHS Boards was revised in a Dear Colleague letter of 1 July 2015 from the Director of Finance, eHealth and Analytics in the Scottish Government Health and Social Care Directorate (SGHSCD) which places an increased emphasis on delivering agreed outcomes and putting the customer at the heart of NHS Scotland Counter Fraud Services (CFS) work.

10.2 Where the Client wishes to nominate the Internal Audit Service to fulfil the Fraud Liaison Officer responsibilities as set out in the Fraud Action Plan and Partnership agreement, the contingency reserve shall be adjusted accordingly to reflect this increased responsibility.

10.3The audit universe shall include the arrangements for complying with relevant HDL/CELs, for responding to suspected criminal offences and for liaising with the CFS as appropriate.

11. Freedom of Information

11.1 Fife NHS Board is subject to the Freedom of Information (Scotland) Act 2002 (the Act).

11.2 As part of our duties under the Act, the Board may publish some of the information clients provide to us in its Freedom of Information publication scheme. The Board may disclose information to anyone who makes a request.

11.3 In all cases, wherever a request for information is received, the Client's nominated Freedom of Information contact point shall be notified in sufficient time to allow an informed decision to be reached without compromising our ability to comply with the timescales set out in the Act.

11.4 If the Client considers that any of the information supplied to us should not be disclosed due to its sensitivity then this should be stated giving reasons for withholding it. FTF will consult with the Client and have regard to its comments or stated reasons for withholding information.

12. Staffing

12.1 The anticipated total number of audit days required per annum to carry out the Internal Audit Service for each client is set out in the Shared Service Agreement.

12.2 FTF shall allocate a sufficient number of employees, sufficiently qualified and experienced to ensure the Internal Audit Service is provided at all times and in all respects to this specification.

12.3 FTF shall ensure that every person employed or contracted by FTF is at all times properly and sufficiently trained and instructed with regard to:

- ✧ the task or tasks that person has to perform
- ✧ all relevant provisions of this specification
- ✧ all relevant rules, procedures and standards of the organisation
- ✧ security
- ✧ patient confidentiality and relevant aspects of Information Governance

12.4 Training and development should be a planned and continuing process. The Chief Internal Auditor should co-ordinate and keep under review the training requirements of all staff engaged on the contract in compliance with national guidance and report on these as part of the Balanced Scorecard.

12.5 The Director of Finance may instruct FTF to remove from work in or about the provision of the service, any person employed by FTF if, in the opinion of the Director of Finance, such person is not providing the service or part thereof to a satisfactory level or is not conforming with client expectations of behaviour or professionalism. FTF shall immediately comply with such instructions and as soon as reasonably practical thereafter provide a replacement individual.

12.6 For the purposes of this paragraph, staff are categorised as follows:

Chief Internal Auditor: member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and three years audit experience

Qualified: member of a CCAB Institute, the Institute of Internal Auditors or an alternative qualification agreed with the Director of Finance including specialist support e.g. computer audit (ITAC etc.) and Risk Management.

Non-Qualified Auditors: appropriately skilled staff including those training towards CCAB or IIA or an appropriate alternative qualification.

During each successive twelve month period of the Agreement, FTF shall maintain, in the performance of the services, the skill mix of staff outlined in Appendix IV. Actual performance against this specified skill mix should be reported within the Annual Internal Audit Report.

12.7 FTF shall be expected to limit the number of staff employed on the contract to ensure sufficient experience and continuity is gained. With regard to this limit FTF should comply with the parameters specified in Appendix IV.

12.8 FTF shall be required to keep detailed time ledger records detailing actual time spent on each audit and the name and qualification of staff. Only time spent working exclusively on the performance of the services and associated chargeable travelling time shall be chargeable. The Director of Finance will have the right to make random spot checks of detailed time ledgers to verify the accuracy of time records.

12.9 NHS Fife shall be entirely responsible for the employment and conditions of service of FTF staff and FTF will be responsible for ensuring that:

- ✧ there are sufficient staff employed at the appropriate levels to fulfil the terms of the Shared Service Agreement
- ✧ staff do not smoke while on the organisation's premises
- ✧ staff do not introduce or consume any drug (including alcohol) on the organisation's premises
- ✧ staff who are under the influence of any drug (including alcohol) do not work or attempt to work on the organisation's premises
- ✧ staff are properly and presentably dressed while on the organisation's premises.

Appendix I

INTERNAL AUDIT SPECIFICATION

PERFORMANCE MEASURES

The following performance measures shall be monitored by FTF, reported to the client Director of Finance bi-annually and included within the Annual Internal Audit Report, with comparative figures for the previous year.

	Planning		**Target**
1	Strategic/Annual Plan presented to Audit & Risk Committee by June 30	Yes/No	Yes
2	Annual Internal Audit Report presented to Audit & Risk Committee by June 30	Yes/No	Yes
3	Audit assignment plans for planned audits issued to the responsible Director before commencement of audit fieldwork.	%	75%
	Delivery		
4	Draft reports issued within 2 weeks of fieldwork completion / exit meeting	%	75%
5	Draft reports issued by target date	%	75%
6	Responses received from client within timescale defined in reporting protocol	%	75%
7	Final reports presented to target Audit & Risk Committee	%	75%
8	Number of days delivered against plan	%	100% at year-end
9	Number of audits delivered to planned number of days (within 10%)	%	75%
10	Number of products delivered against plan at year end	%	75%
11	Percentage of audits that directly relate to a strategic risk	%	75%
12	Skill mix	%	50%
13	Staff provision by category	Pie chart	As per SSA/Spec
	Effectiveness		
14	Client satisfaction surveys	Bar chart	Average score of 3

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

1. The timings for each stage are detailed in the table below.

2. Executive Directors (the Responsible Directors) are designated as being responsible for liaising with Internal Audit within specified areas, consistent with the Scheme of Delegation.

3. Internal Audit contact the Responsible Director to request that they review and approve the Assignment Plan and to ascertain if the Responsible Director or a nominated operational manager within the directorate (the Responding Officer) will clear the draft report.

4. The Responsible Director confirms agreement of the assignment plan by e-mail prior to the commencement of the audit, and it is copied to the Director of Finance and Strategy as Lead Officer for the Audit and Risk Committee.

5. At the end of audit fieldwork, the summary of findings is discussed and agreed with the appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. For example, where the report narrative or recommendations have a financial implication or comment on the work of the Finance Department, the Director of Finance and Strategy or Assistant/Deputy Director of Finance will be consulted and included in the distribution of the first draft of the report.

6. Following Regional Audit Manager and/or Chief Internal Auditor review, a draft report is issued to the officer nominated to clear the draft report i.e. the Responsible Director or Responding Officer identified at step 2. In the covering e-mail the nominated officer is asked to confirm the factual accuracy of the report and provide formal management responses to the recommendations within the report.

7. Following discussions with the Responding Officer/Responsible Director, management responses are recorded and line management responsibilities determined together with a timeframe for action. It is the responsibility of the Responding Officer/Responsible Director to ensure that the response reflects the official position of the Directorate and to obtain responses from any other relevant officers.

8. The Directorate response the draft report is then issued to the Director of Finance and Strategy for clearance and copied to the Responding Officer and Responsible Director so that they can confirm that their response has been recorded accurately.

9. Following clearance by the Director of Finance and Strategy the final report is formally issued by Internal Audit to all officers on the distribution list, including External Audit.

10. Audit and Risk Committee members receive the Internal Audit reports as they are finalised by the Office Manager and a summary is provided as an appendix to the progress report issued by the Regional Audit Manager for the next Audit and Risk Committee.

11. The recommendations will be added to the AFU System by Internal Audit and progress reported to the Audit and Risk Committee.

12. All final audit reports may be presented to the Executive Directors Group, relevant Standing Committee and, where appropriate, the Fife IJB Audit and Risk Committee.

Dispute resolution

13. In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance and Strategy and, if necessary, to the Chief Executive.

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
	Annual Audit Plan agreed	Formulated from Strategic Audit Plan for agreement by Audit & Risk Committee	Regional Audit Manager/ Chief Internal Auditor with Director of Finance and Strategy	
1	Assignment Plan agreed	Terms of reference for the assignment agreed with Responsible Director and / or Responding Officer.	Regional Audit Manager with Responding Officer/ Responsible Director.	Within 2 weeks of issue
2	Fieldwork commenced	Audit team conduct audit assignment in accordance with Assignment Plan	Principal/Auditor with co-operation of operational staff	
3	Fieldwork completed	Audit findings evaluated and summary of findings discussed and agreed with appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. Draft report prepared for review.	Principal/Auditor in discussion with operational staff prior to Audit Manager review	Within 1 week of fieldwork end
4	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans. If audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area should be consulted on the report content.	Regional Audit Manager with Principal/ Auditor to Responding Officer/ Responsible Director.	Within 2 weeks of fieldwork end
5	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix.	Responding Officer with agreement of Responsible Director	Within 2 weeks of draft report release

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
6	Report issued to Director of Finance and Strategy	Audit report reviewed for clearance.	Regional Audit Manager	Within 1 week of Directorate response
			Director of Finance and Strategy/ Responding Officer/ Responsible Director	Within 1 week of receiving report
7	Final Report released	Report issued in full to relevant officers and External Auditor.	Regional Audit Manager/Office Manager to Director of Finance and Strategy, Responding Officer & Chief Executive	Within 1 week of Director of Finance and Strategy clearance

Flowchart

Stage	Explanation	Timeframe
Assignment Plan	Assignment Plan issued to relevant Client Director by Principal Auditor/Auditor. When agreed, the assignment plan is issued to the Director of Finance and Strategy.	For return within 2 weeks
Fieldwork	Fieldwork carried out by Principal Auditor/Auditor according to the Annual Internal Audit Plan. On completion of fieldwork the summary of findings is discussed and agreed with the appropriate staff. A draft report will be prepared and file review undertaken.	File Review for completion within 1 week
Issue of Draft Report to Directorate	The draft report will be issued to the Responding Officer for factual accuracy check and management responses.	For return within 2 weeks
Directorate Response	Management responses are received and incorporated within the report.	Within 1 Week
Report to CE and Director of Finance	Report is issued to Director of Finance and Strategy for review, comment and approval.	For return within 1 Week
CE / Director of Finance Responses	The responses from the Director of Finance and Strategy will be incorporated into the report.	Within 1 Week
Report finalised and issued	The Office Manager will finalise and issue the report to the relevant Client Director and Officers.	By the end of the next day
Recom-mendations added to AFU	The recommendations will be added to the AFU System by the AFU Coordinator and progress reported to the Audit & Risk Committee.	On receipt of report

The final report will be presented to the Executive Directors Group, Audit & Risk Committee, the relevant Standing Committee, and the Health & Social Care Partnership

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS

NHS FIFE

FOLLOW-UP PROTOCOL ON INTERNAL AND EXTERNAL AUDIT REPORT ACTION PLANS

1. INTRODUCTION

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As Accountable Officer, the Chief Executive is ultimately responsible for ensuring that the organisation has effective management systems in place to safeguard public funds. Good practice guidance, as laid out in the Audit and Assurance Committee Handbook, emphasises the importance of follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented.

2. MANAGEMENT FOLLOW-UP ON INTERNAL AUDIT REPORTS

- Internal Audit will follow up all agreed audit action points arising from Internal Audit reports. Internal audit will only review progress against external audit recommendations where relevant to internal audit fieldwork
- Once an action point falls due, the Responsible Officer (the officer noted in the Internal Audit Action Plan as responsible for implementing the agreed action) will provide Internal Audit with an update on the current status of the action point, indicating whether it has been completed or not and, if not completed, provide a reason for the outstanding element, together with a revised due date for completion of the entire action point.
- Actions classified by Responsible Officers as no longer relevant, or where an extension of the due date is requested, will require evidence to support to request. . Internal audit will conclude on whether these are reasonable.
- The Responding Officer will also provide supporting evidence to demonstrate that the required action has been taken and that it has been effective. Internal Audit will review in detail any responses which do not appear adequate to address the control weakness identified in the original report, or where the evidence does not fully support the conclusion drawn.
- Where significant inaction by a Responsible Officer is apparent and intervention is required, the internal audit will discuss this with the relevant Director/Senior Manager. Where the matter cannot be resolved in this way, it will be escalated to the Director of Finance and Strategy and, ultimately, the Chief Executive.
- After each Audit and Risk Committee meeting where an Audit Follow Up report has been presented, the report will also be taken to the Executive Directors Group to allow consideration of any long outstanding responses, repeated

extensions to due by dates, actions not completed and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response.

- Internal Audit will be responsible for presenting regular reports on follow-up to each Audit and Risk Committee. These reports will contain a graphical representation of progress towards implementation of all internal audit recommendations, detail progress on all outstanding recommendations.
- The report will detail the most recent position on summary of progress, detailed action status by report, reasons for extensions granted, outstanding recommendations and Internal Audit validation.

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2.1 A database is maintained by Internal Audit of agreed management action listing the :

- Individual findings, recommendations and management responses arising from each Action Plan;
- Level of priority given to each recommendation;
- Dates by which the actions are due to be completed;
- Responsible Officer for each recommendation;
- Evidence of completion or updates on progress; and,
- Details or requests for extensions to action by dates
- Validation assessment by Internal Audit.

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

3.1 The follow up of External Audit reports remains the responsibility of the Director of Finance. Audit Scotland reports are far fewer in number and generally speaking will identify a Director as being responsible for the action to be taken.

3.2 All relevant reports are brought to the attention of the Executive Directors Group irrespective of whether or not there are specific action points to be addressed.

3.2 The management follow-up process is set out as below.

Management Follow-Up Process for all External Audit Report Action Plans
1 The Director of Finance and Strategy will present all Audit Scotland Reports to the Executive Directors Group. 2 The relevant Director will prepare an action plan for any specific points to be addressed. These will roll forward for each future meeting of the Executive Directors Group, at which progress and completion are due to be noted (twice yearly) until all outstanding actions are completed. 3 The Director of Finance and Strategy will present an annual update on progress to the Audit and Risk Committee in accordance with the Committee's Workplan as determined from time to time.

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

For the purpose of paragraph 12.6, FTF shall maintain at least the following skill mix of staff in the performance of the service. Any variation of these shall require the express approval of the Client.

Chief Internal Auditor	2.5 per cent
Regional Audit Manager	10 per cent
Other Qualified	37 per cent
Auditor	50 per cent

For the purpose of paragraph 12.7, it is expected that at least 50% of the internal audit work shall be undertaken by qualified staff and furthermore that 50% of all IT audit work shall be undertaken by staff with the relevant qualification.

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

PUBLIC SECTOR INTERNAL AUDIT STANDARDS

https://www.gov.uk/government/publications/public-sector-internal-audit-standards

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with assurance on the progress of the 2022/23 plan.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team is progressing the 2022/23 Annual Internal Audit Plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

2.3 Assessment

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the Audit Follow-up System, which is maintained and reported to the Audit and Risk Committee by Internal Audit.

Appendix A shows:

- Finalised Internal Audit Reports
- Internal Audit Reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- Summary of Internal Audit Findings in Final Internal Audit Reports issued since the last Audit and Risk Committee

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Discuss** and take **assurance** of the progress on the delivery of the Internal Audit Plan

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 3 March 2023.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 5 December 2022. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2022/23	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B08/23 – Internal Control Evaluation (ICE)	N/A	11 Recommendations	24 November 2022	2 March 2023
B09/23 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee and a year-end summary will be presented to May 2023 Audit and Risk Committee.

NHS Fife Draft Reports Issued

	Draft issued
B19-23 Whistleblowing	13 March 2023
B21-23 Financial Process Compliance	14 March 2023
B22-23 Patients Funds	14 March 2023

NHS Fife Work in Progress and Planned:

Audit 2022/23		Status	Target Audit and Risk Committee
B10/23	Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	WIP	A year-end summary will be presented to May 2023 Audit and Risk Committee.
B11/23	Assurance Framework	WIP	A year-end summary will be presented to May 2023 Audit and Risk Committee.
B12/23	Risk Management[1]	WIP	A year-end summary will be presented to May 2023 Audit and Risk Committee.
B13/23	Resilience and Business Continuity	WIP	May 2023
B14/23	Strategic Planning (Includes B13/22)	Finalising Draft Report	Report will be issued by 17 March 2023 - May 2023 meeting
B15/23	Operational Service Planning – Delayed Discharges	Planned	May 2023
B16/23	Health and Social Care Integration	WIP	Contribution to deliver Fife IJB audit plans. IJB reports will be shared with the NHSF Audit and Risk Committee.
B17/23	Medicines Management	WIP	May 2023
B18/23	Workforce Planning	Finalising Draft Report	Report will be issued by 17 March 2023 - May 2023 meeting

[1] Internal Audit attend the Risk Opportunities Group and are providing advice and feedback as the Risk Management Framework evolves.

Fife IJB Work in Progress and Planned:

Audit	Status	Target Audit and Risk Committee
F05-22 Strategic Plan	Finalising Draft Report	May 2023
F06-22 Clinical and Care Governance	Finalising Draft Report	May 2023
F04-23 Contract/Market Capacity	WIP	TBC
F05-23 Workforce Planning	Planned	TBC

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of March 2022 where a progress report was considered.

1. B08-23 – Internal Control Evaluation (ICE)

See separate agenda item 7.4

2. B09-23 Audit Follow Up

See separate agenda item 7.3

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager/ A Brown, Principal Auditor**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

Good practice guidance, as laid out in the Audit Committee Handbook, emphasises the importance of effective follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented.

The Blueprint for Good Governance in NHS Scotland (second edition) includes the following guidance regarding the follow-up of actions to address internal audit recommendations:

> *'It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.' [Section D13 – page 59]*

2.2 Background

The EDG consider the progress on internal audit actions quarterly with Directors being reminded of the need to ensure good progress is made in clearing outstanding issues.

External Audit recommendations continue to be followed up through NHS Fife Finance Directorate and Internal Audit continue to review progress against External Audit recommendations where relevant to internal audit fieldwork.

Internal Audit validate the evidence supplied by responding officers for actions they are declaring as completed to confirm that those actions address the recommendations made.

This report now includes progress regarding recommendations arising from our Internal Control Evaluation (ICE) and Annual reports.

We have now adapted our AFU report so it can demonstrate the guidance within the Blueprint for Good Governance in NHS Scotland (second edition), interpreting this guidance as follows:

> ***Actions should be implemented within 1 year of the recommendation having been made. This is calculated from the date the final report, including the recommendation, was issued.***

We have amended the tables and graphs to clearly show the actions related to recommendations that were reported more than one year ago so that particular attention can be focussed on clearing these. We will present an updated AFU protocol, reflecting the changes in reporting, to the next ARC meeting for approval.

2.3 Assessment

We include reports which have actions with a status of Extended, Outstanding or Not Yet Due. Reports with all actions either completed and validated or superseded are not included. This is to promote focus on addressing the remaining recommendations.

The table below shows the status of all remaining internal audit recommendations, other than ICE and Annual Report recommendations, as at 28 February 2023, with comparable figures from the last Audit Follow-Up (AFU) report as at 22 November 2022 (Ext = Extended, O/S = Outstanding & NYD = Not Yet Due).

	Feb 2023			**Nov 2022**		
Remaining Actions	**29**			**33**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	8	7	0	8	23	2
Recommendations less than 1 year (*Appendix C)*	14	0	0			

The table below shows the status of all remaining ICE and Annual Report recommendations, as at 28 February 2023. The latest ICE report (B08/23) will be included in the next report. (Ext = Extended, O/S = Outstanding & NYD = Not Yet Due).

	Feb 2023			Nov 2022		
Remaining Actions	**2**			**5**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	2	0	0	5	0	0
Recommendations less than 1 year (*Appendix C)*	0	0	0			

Progress summary

The following reports, featured in our December 2022 report, but have either been completed and validated or superseded by recommendations in more recent reports:

Report	**Remaining Actions Status**
B22/21 Manual Handling Training	All actions completed and validated.
B06/23 Internal Audit Annual Report 2021/22	All actions completed and validated.

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

We have assessed progress to date for responses in relation to those remaining recommendations with extended target implementation dates and a RAG status is included to aid prioritisation.

Where no appropriate or sufficient response is received from the responsible officer we liaise with the Director of Finance and Strategy and the Board Secretary to escalate.

2.3.1 Quality/ Patient Care

There are no direct implications for Quality/Patient Care as a result of this report.

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core

consideration in planning all internal audit reviews.

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor and the Director of Finance and Strategy ahead of submission to the Audit and Risk Committee.

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

- Take **assurance** and **consider** the current status of Internal Audit recommendations recorded within the AFU system
- **Note the changes to the style of AFU reporting to meet the related requirements of the** Blueprint for Good Governance in NHS Scotland (second edition).

3. List of appendices

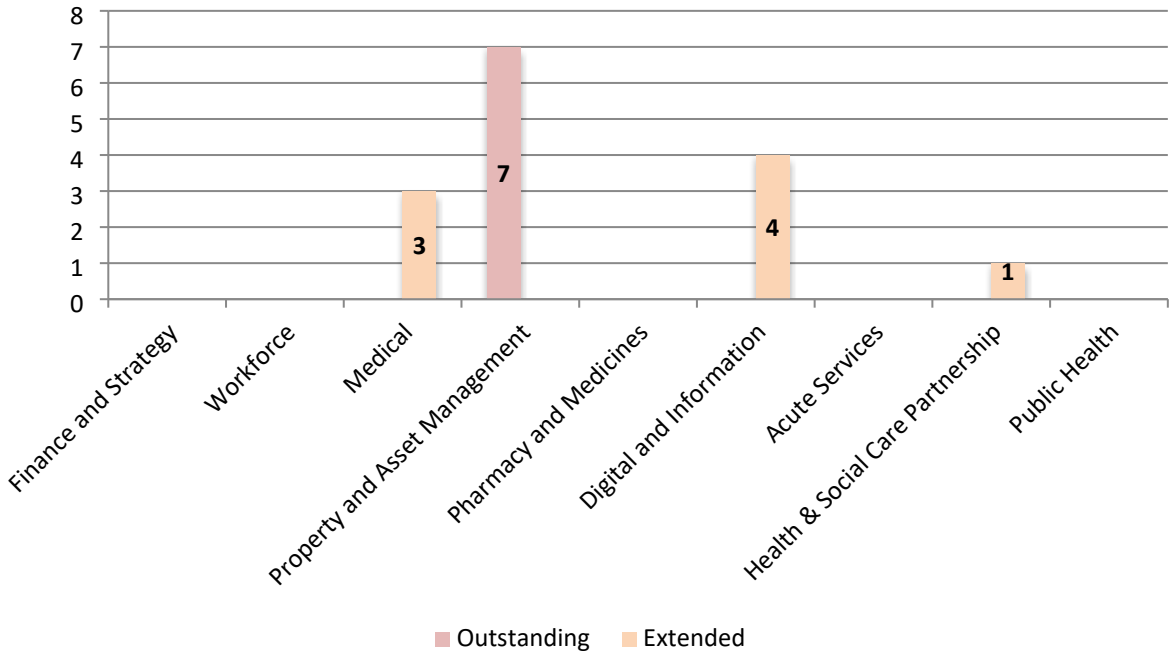
The following appendices are included with this report:

Report Contact

Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

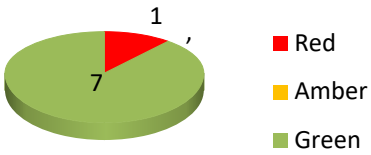
Recommendations More Than 1 Year

Outstanding and Extended by Directorate



Extended Recommendations RAG Status and Priority

RAG Status



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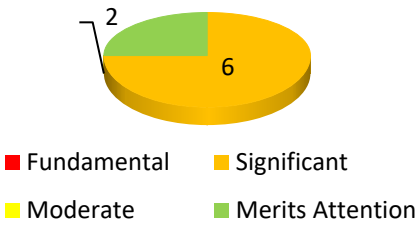
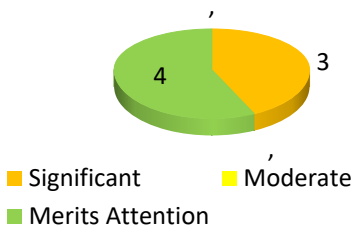


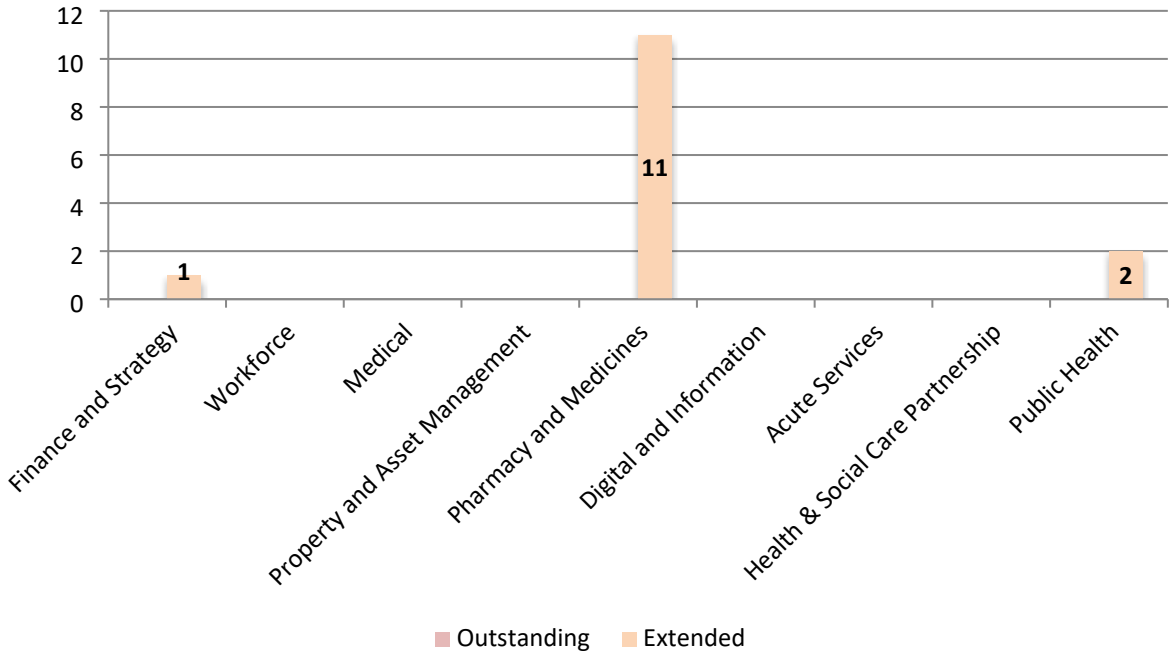
Outstanding Recommendations Priority

Priority



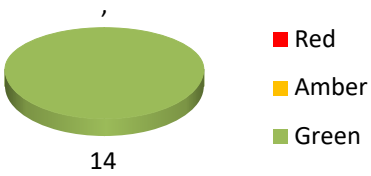
Recommendations Less Than 1 Year

Outstanding and Extended by Directorate

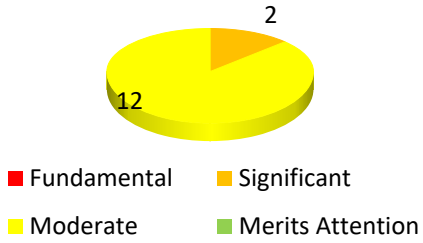


Extended Recommendations RAG Status and Priority

RAG Status



Priority



Outstanding Recommendations Priority

Priority

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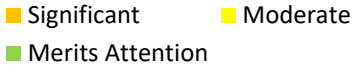

Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B14/21 Sharps Management	Dec-21	14	10	0	4		1	3	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		1	0	0		-
B20/21 Adverse Events Management	Mar-21	1	0	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	0	0	4		0	4	0		-
B23/21 ITIL Processes	Jul-21	6	2	0	4		4	0	0		-
2020/21 Totals		**32**	**17**	**0**	**15**		**8**	**7**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	0	0	11		11		0		-
B20/22 Financial Process Compliance	May-22	1	0	0	1		1	0	0		-
B23/22 Resilience	Apr-22	5	3	0	2		2	0	0		-
2021/22 Totals		**17**	**3**	**0**	**14**		**14**	**0**	**0**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**49**	**20**	**0**	**29**		**22**	**7**	**0**		**0**

Previous ICE and Annual Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2020/21											
B08/21 ICE	Mar-21	6	5	0	1		1	0	0		-
2020/21 Totals		**6**	**5**	**0**	**1**		**1**	**0**	**0**		**-**
2021/22											
B08/22 ICE	Feb-22	12	11	0	1		1	0	0		-
2021/22 Totals		**12**	**9**	**0**	**3**		**3**	**0**	**0**		**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**18**	**16**	**0**	**2**		**2**	**0**	**0**		**-**

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an IJB Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ ~~30 Sep 22~~ ~~31 Dec 22~~ 31 Aug 23		There are several component parts to the action required including a revised NHS Fife Risk Management Framework and related GP/R7 - Risk Register and Risk Assessment policy reflecting the IJB Risk Management Strategy being agreed by the NHS Fife Audit & Risk Committee. This is scheduled to be presented in May 2023. Further action includes reflecting the relationship with the IJB regarding risk management in the NHS Fife Risk appetite. This is due to take place in July 2023.
B14/21 Sharps Management	2f	M A	Update the Adverse Events Policy to: • clearly outline processes for review and analysis of Health and Safety Incidents related to staff • refer to lessons learned needing to be applied across the organisations to all departments and wards that they are applicable to.	Associate Director of Quality and Clinical Governance **Medical Director**	~~26 Mar 21~~ ~~30 Apr 22~~ ~~31 Oct 22~~ 31 Aug 23		The Adverse Events Procedure will be developed and endorsed by June 2023 and will be published on Stafflink.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B19/21 Clinical Governance Strategy and Assurance	1	S	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance and related governance improvements.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Jan 22~~ ~~31 May 22~~ ~~31 Oct 22~~ 31 Jul 23		The recommendation from this report has many component parts and although the finalisation of the draft Clinical Governance Strategic Framework will go a long way to addressing the recommendations there are others that also need to be addressed. These have been discussed with the relevant manager and revised timescales for these have been agreed.
B20/21 Adverse Events Management	1	M A	Address concerns of DATIX Action Module users expressed by the comments made in this review regarding unfamiliarity with the DATIX Action Module and the lack of a full understanding of users' individual responsibilities Based on the findings of the initial review in B19/20 – Adverse Event Management, plus the additional comments made by users in this review, consideration should be given to a review of the framework and processes currently in place, to determine if any system changes could result in benefits and improvements, which would reduce the number of actions actually outstanding and those incorrectly recorded as outstanding.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31-May-21~~ ~~30-Apr-22~~ ~~31 Oct 22~~ 30 Apr 23		A draft Adverse Event Policy was presented to CGOG on 20 December 2022 and a decision taken to split the document into a policy document and a separate procedural document. CGOG was also advised that a resource pack will also be published. A final version of the Adverse Events Policy was subsequently considered by CGOG at its February 2023 meeting. It was originally intended to be presented in January 2023 but was not on the CGC agenda for its March 2023 meeting. Extension to April 2023 was requested to allow leeway given anticipated challenges over the winter period and to allow for publication on Stafflink. However the next CGC meeting is in May 2023 so a further extension will be required. This will be confirmed with the Associate Director of Quality and Clinical Governance.
B23/21 ITIL Processes	3	S	Digital and Information should engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes to improve the efficiency of IT Service management in these areas. The timing of these actions will need to follow the cost benefit analysis and outcome referred to in action plan point 1 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of other services.	Head of Digital Operations **Associate Director - Digital and Information** 5	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		Cost / Benefit paper presented to D&I Board 19/10/21. Recruitment now completed and lead resource starting on 5th September 2022. Further resource is at preferred candidate stage. Then initial engagement can begin. Time required to allow for engagement with other services regarding introducing ITIL practices.
	4	S	The NHS Fife Policy and Procedure for Change Management should be reviewed prior to the forthcoming change of IT Service Management	Service Delivery Manager	~~30-Sep-21~~ ~~31-Dec-21~~		Extension required to allow migration of change management process from Cherwell to ServiceNow which is now possible following technical difficulties

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			review should include determination of mandatory fields to be completed for all changes. Recording of risks related to changes should be undertaken in a consistent manner and should always include scoring of the risks based on impact and likelihood. The relevant staff should be reminded of the need to complete and attach the appropriate checklist for changes associated with server decommissioning.	**Digital and Information**	~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		
	5	S	The setting of required approvals should not be undertaken by the change requester. This should be automated as far as possible based on the type of change and its impacts and where the change is exceptional the approval requirements should be set by another member of the Digital and Information Team (eg the Change Manager). The move from Cherwell to ServiceNow should include determination of how approvals for changes are recorded so that this is clear and does not result in any doubt over whether the change has been appropriately authorised. Brief minutes of each Change Advisory Board meeting held should be recorded including listing those in attendance and decisions made.	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.
	6	S	A section should be added to the Service Management application (ServiceNow) to indicate whether the change falls into one or more of the 3 criteria listed in the Change Management Procedure as requiring the emergency change process to be invoked. A review of changes processed as emergency changes should be undertaken to identify changes that have been processed as such but do not meet the criteria for invoking the emergency change procedure. The IT Service Management application	Service Delivery Manager **Associate Director - Digital and Information** 6	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			or their Deputy for emergency changes classified as high risk.				
20/21 Extended	**8**						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B08/21 – ICE Report – 2020/21	1	S	Production of the Population Health & Wellbeing Strategy and Delivery Plan and the Governance arrangements.	**Chief Executive**	~~31 Mar 22~~ 31 Mar 23		Development activities were paused as a consequence of the pandemic. However this has now progressed with the Population Health and Wellbeing Strategy to be presented to Fife NHS Board in March 2023.
20/21 Extended	**1**						
2021/22							
B08/22 – ICE Report – 2021/22	7	M A	Linking the Financial Sustainability Corporate Risks to Strategy, PMO Savings Programme & relevant External audit recommendations	**Director of Finance and Strategy**	~~31 Mar 22~~ 31 Mar 23		Risk profile dashboard, deep dive reports and the IPQR including the risk profile dashboard have been presented to Fife NHS Board and its standing committees. Risks 13 and 14 related to Financial Sustainability include reference the FIS Programme, CIPs and the SPRA process in their mitigations but are not specifically referred to in the finance section of the IPQR.
21/22 Extended	**1**						
Total	**2**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Further Information	Priority	Original and Extended Due Dates
2020/21 - Outstanding							
B14/21 Sharps Management	22 Dec 20	3a 3b 3c	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee.	H&S Manager **Director of Property and Asset Management**	A proposal to disband the Sharps Strategy Group and include its responsibilities as an item on the Acute Health & Safety Committee agenda was discussed at the H&S Sub-Committee on 20 January 2023. It is not yet clear how the responsibilities will be reflected in the terms of reference of the Acute Health & Safety Committee or how responsibilities related to Sharps Management in the HSCP will be covered.	S	~~Feb-21~~ ~~Jun-21~~ ~~Feb-22~~ ~~Jul-22~~
B21/21 Medical Equipment and Devices	08 Nov 21	1	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group.	Head of Estates **Director of Property and Asset Management**	There has been engagement with the relevant manager and Internal Audit but we have not yet agreed upon appropriate extended dates for the following evidence to be provided: • An updated General Policy GP/E4 – Medical Equipment Management Policy approved by CEMG and published on Stafflink? [Point 1] • Publication of E14.1 – Equipment Procurement Operational Policy on Stafflink [Point 1] • The ERF form being further updated to include provision for the level of training required and the training to be provided to be recorded [Point 2] • Provision of a sample of completed ERFs to evidence the completion of the fuller information required on the new form [Points 2 & 3] • Updated Terms of Reference of the including a member from IT/Data Support in the membership? [Point 3] • Discussion of CEL 35 (2010) KPIs have been discussed at CEMG [Point 4]	MA	~~Jan-22~~ ~~Jul-22~~
		2	Equipment Request Form (ERF) requires updating to include prompts for sufficient detail to be recorded regarding consultation, training requirements, maintenance costs and needs assessment.			MA	~~Jan-22~~ ~~Jul-22~~
		3	As per 2 above.			MA	~~Jan-22~~ ~~Jul-22~~
		4	The CEMG should review the KPIs within Annex 2 of CEL 35 (2010) and consider whether receipt of these would benefit its decision making process and arrange for the receipt of such information in future. In addition it terms of reference (currently being reviewed) should be updated to note the monitoring of such KPIs.			MA	~~Jan-22~~ ~~Jul-22~~
20/21 Outstanding		**7**					
TOTAL		**7**					

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22 - Extended							
B16/22 Prescription Stationery Security	1	M	Checking of staff ordering prescription stationery to confirm that they are authorised to order the stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		The temporary arrangements put in place during the pandemic are to be made permanent with Nurses ordering prescription stationery to quote their registration PIN on requests to confirm that they are authorised to order the stationery. The SSUMPP is to be updated to reflect this change and will be published in March 2023.
	2a	M	Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		Risk assessments have been undertaken and mitigations identified. Awaiting feedback from Estates regarding when the mitigations will be implemented.
	2b	M	Implementing a protocol for changing any combination locks remaining in use whenever anyone who knew the code leaves the service.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		As per 2a above – awaiting feedback from Estates on when mitigations can be implemented.
	2c	M	SOP CDP021 and the SSUMPP to be updated to include the process for dealing with prescription stationery that is no longer suitable for use including the need for a separate member of staff being required to witness destruction of prescription stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SOP CDP021 currently being updated. SSUMPP being updated – scheduled for publication on Stafflink in March 2023.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	2d	M	SOP CDP021 updated to include the times that the check of the 'Controlled Stationary – Record of Issues and Receipts log' for each pad is required to be undertaken.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SOP CDP021 currently being updated.
	3a	M	Review of SSUMMP against NSS guidance for prescription stationery security and resultant updates made to the SSUMMP (eg the requirement to hold records prescription stationery stock levels for 3 years and to hold the minimum stock required based on usage).	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SSUMPP being updated – scheduled for publication on Stafflink in March 2023.
	3b	M	Ward/Department advice from Pharmacy (eg emails or memos) and distribution of standard templates for: i. conducting risk assessments of storage areas used for prescription stationery incorporating NSS requirements ii. stock control record keeping iii. issue and return record keeping	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SSUMPP being updated – scheduled for publication on Stafflink in March 2023. Drop in sessions on TEAMS will be provided to allow the changes to the SSUMPP to be highlighted to staff throughout NHS Fife and the HSCP who interact with medicines.
	3c	M	As per 3b re advising wards/departments to undertake risk assessments of the areas they use to store prescription stationery and to take any remedial action required to address any unmitigated risks identified. Also evidence of advising wards/departments that the risk assessment should be revisited whenever there are any changes made to the storage area or changes to legislation.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SSUMPP being updated – scheduled for publication on Stafflink in March 2023. Drop in sessions on TEAMS will be provided to allow the changes to the SSUMPP to be highlighted to staff throughout NHS Fife and the HSCP who interact with medicines.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3d	M	As per 3b re advising wards/departments to undertake record keeping in a consistent manner in compliance with the SSUMPP/SOP and NSS guidance and specifically of the requirement to retain stock records for 3 years.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SSUMPP being updated – scheduled for publication on Stafflink in March 2023. Drop in sessions on TEAMS will be provided to allow the changes to the SSUMPP to be highlighted to staff throughout NHS Fife and the HSCP who interact with medicines.
	3e	M	Details of the process introduced to check prescription stationery orders received to confirm that these are consistent with wards/departments only holding the stock they require (and documentation of this in the SOP or SSUMMP).	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SOP CDP021 currently being updated.
	3f	M	Evidence (emails/memos) of wards & departments being asked to keep their prescription stationery stock and use records separately from where the prescription stationery is stored and to hold the minimum stock of prescription stationery required.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ 30 Apr 23		SSUMPP being updated – scheduled for publication on Stafflink in March 2023. Drop in sessions on TEAMS will be provided to allow the changes to the SSUMPP to be highlighted to staff throughout NHS Fife and the HSCP who interact with medicines.
B20/22 Financial Process Compliance	1	M	Providing EDG with regular Invoice Register reports including commentary on progress to reduce the number of disputed invoices.	Head of Financial Services and Procurement **Director of Finance and Strategy**	~~31 Aug 22~~ ~~31 Oct 22~~ 31 May 23		The Head of Financial Services and Procurement advised of difficulties in getting paper included on EDG agenda but it is to be included at their next meeting.
B23/22 Resilience	1c	S	Presenting finalised Major Incident Operational Plan to CGC and providing an update on Action Cards stakeholder testing to the Resilience Forum.	Head of Resilience **Director of Public Health**	~~30 Sep 22~~ ~~30 Nov 22~~ 31 May 23		The major incident framework plan did not gain approval for ratification at EDG on 19 January 2023 but good feedback was received and an approach is to be undertaken to revise the Major Incident Operational Plan and supporting documents in a controlled manner.
	1e		Providing an annual assurance report and statement from the Resilience Forum to the Clinical Governance Committee to allow it to	Head of Resilience **Director of Public Health**	~~31 Mar 23~~ 31 May 23		There is a significant amount of work being undertaken by resilience department staff currently and this has impacted upon our ability to prepare a detailed annual assurance report from the Resilience

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			its own annual assurance report and statement.				report. A shorter report will be prepared in the form of an SBAR and will be presented to CGC within a timeframe that allows it to consider the assurance on resilience prior to concluding on its own annual assurance report. The SBAR will include assurance on: • Items discussed at the Resilience forum in 2022/23 • Any changes to risks associated with resilience as a result of discussions at the resilience forum • Specific updates on: o Business Continuity Plans o Resilience Assurance Reporting Mechanisms o Major Incident Operational Plan progress.
21/22 Extended	**14**						
Total	**14**						

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total						

Action Status	
Term	**Definition**
Complete	Client has informed Internal Audit that the action has been implemented
Superseded	Action has been updated within a further audit report
Extended	Client has requested further time to implement the action (see A**ppendix D**)
Outstanding	The original, or extended, due date has passed, and the client has not provided an update or requested an extension to the due date (see A**ppendix E**)
Not Yet Due	Original action by date has not yet occurred
Not Validated	Client has informed Internal Audit that the action has been implemented but our validation process found that further evidence is required to support this conclusion (see A**ppendix F**)

Recommendation Priority	
Term	**Definition**
Fundamental (F)	Non-Compliance with key controls or evidence of material loss or error. Action is imperative to ensure that the objectives for the area under review are met.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Moderate (M)	Weaknesses in design or implementation of controls which contribute to risk mitigation. Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.

RAG Status Definitions for Importance of Extended and Outstanding Recommendations		
RAG Status		**Definition**
Red		**Action is imperative to ensure that the objectives for the area under review are met and risks are mitigated.**
Amber		**Stated actions have not been progressed sufficiently to mitigate the identified risk. Completion of updated actions should ensure objectives are achieved.**
Green		**Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks.**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Internal Control Evaluation Final Report 2022/23**
Responsible Executive/Non-Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Tony Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Internal Control Evaluation (ICE) is undertaken each year by Internal Audit to provide assurance on the overall systems of internal control that support the achievement of the Boards objectives.

The Chief Internal Auditor presented the draft ICE report to the 5 December 2022 Audit & Risk Committee. The draft report was considered by the Executive Directors Group and management responses provided for each audit recommendation. The final report is attached as Appendix 1.

2.2 Background

As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and managing and controlling all the available resources used in his/her organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

2.3 Assessment

Following discussions with the responsible Executive Director(s), management responses were provided to each audit recommendation.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- Take **assurance** on the finalised Internal Control Evaluation, with updated management responses to the audit recommendations.

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Control Evaluation B08/23

FTF Internal Audit Service

Internal Control Evaluation 2022/23

Report No. B08/23

Issued To: **C Potter, Chief Executive**
M McGurk, Director of Finance and Strategy

G MacIntosh, Head of Corporate Governance/Board Secretary
Executive Directors Group
H Thomson, Board Committee Support Officer

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	25 November 2022
Management Responses Received	27 February 2023
Target Audit & Risk Committee Date	8 December 2022
Final Report Issued	**6 March 2023**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The NHS in Scotland remained on an emergency footing until 30 April 2022. NHS Fife is now at an advanced stage of developing its Population Health and Wellbeing Strategy, which should demonstrate how NHS Fife will deliver services in a post Covid environment whilst reflecting on the financial and staffing challenges facing the NHS.
3. The NHS Recovery Plan 2021-26, issued in August 2021, sets out key headline ambitions and actions to be developed and delivered now and over the next 3 years. The aim of the plan is to drive the recovery of the NHS in Scotland, not just to pre pandemic levels but beyond.
4. The NHS Fife 2022/23 Annual Delivery Plan was submitted on 29 July 2022. The Scottish Government (SG) 2022/23 Annual Delivery Planning Guidance, issued in May 2022, set out a timeline which indicated medium term plans would be required by the end of January 2023. Guidance for the 2023-24 Planning was issued by the SG on 14 November 2022.
5. The internal audit plan provides cyclical coverage of all key elements of Corporate, Clinical, Staff, Financial and Information Governance. The strategic risk profile of the organisation altered significantly as a consequence of the pandemic, and NHS Fife is in parallel making progress in revising and developing its risk management framework. We have prioritised our audit work to provide assurance on the areas of likely highest risk.
6. Together, the Internal Control Evaluation (ICE) and annual report provide an opinion on the overall systems of internal control, incorporating the findings of any full reviews undertaken during the year. The ICE and Annual Internal Audit Report do not, and cannot, provide the same level of assurance as a full review but do allow an insight into the systems which have not been audited in full, and provide early warning of issues and allow a holistic overview of governance within NHS Fife.
7. This ICE also provides a detailed assessment of action taken to address internal audit recommendations from previous ICE and Annual Reports, and assesses the adequacy and effectiveness of internal controls, which should allow remedial actions to be taken before year-end, allowing the annual accounts process to be focused on year-end assurances and confirmation that the required actions have been implemented.
8. Whilst there was no overarching corporate/strategic risk relevant to this review, our audit assessed the design and operation of the controls in place and specifically considered whether:
    - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

9. Ongoing and required developments and recommended actions are included at Section 2.
10. The Annual Internal Audit Report was issued on 13 June 2022 and was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG), and other papers.
11. As well as identifying key themes, the Annual Internal Audit Report made four specific recommendations as follows:

- Provision of a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered within the financial budget, with clarity around elements of the strategy that will not be delivered by the end date of 31 March 2024.
- An Implementation Plan for delivering the Property and Asset Management Strategy (PAMS) should be properly documented, approved and monitored to ensure the delivery of actions and outcomes and provide assurance to the Board that the PAMS is being delivered.
- Enhanced written reports to the Staff Governance Committee (SGC) indicating how ongoing workstream and other activity meets the appropriate Staff Governance Standards (SGSs), to be presented in accordance with its Workplan. Any related reports, such as the Health and Wellbeing Update, should also state which strands they provide assurance on and where possible report on the impact as well as the implementation of any actions taken.
- NHS Fife should be provided with an update/precis on work being undertaken in response to Ministerial Steering Group (MSG) recommendations, to foster closer working relationships with colleagues in local authorities and IJBs.

12. Outstanding actions from previous ICE and Annual Internal Audit Report recommendations are shown in table 1. 11 actions have been completed since the issue of our Annual Internal Audit Report.

13. In this report we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 11 recommendations for which management have agreed action to be progressed by year end. Whilst this appears to be a large number given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Fife.

14. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

15. Detailed findings are shown later in the report, which also shows, for context, relevant Corporate Risks against each strand of Corporate Governance. Key themes emerging from this review and other audit work during the year are detailed in the following paragraphs.

16. Audit Scotland – NHS Scotland 2021, issued February 2022, previously stated that "*the NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures*." Since then, the overall financial position has worsened considerably across the whole of NHSScotland. Previous Internal Audit reports have recorded similar concerns and highlighted the strategic changes required in order to address them. The ongoing impact of UK government budget changes, the pandemic, rising inflation and associated pressure on public pay, substantial rises in waiting lists, difficulties in recruitment, extremely ambitious SG targets across a range of areas and many other challenges have all increased financial risk for NHS Fife, NHSScotland and the public sector in general including our Local Authority partners.

17. We previously highlighted the risks associated with the National Workforce Strategy for Health and Social Care and the need for realistic plans within NHS Fife. Since then, the NHS Fife Workforce Plan 2022-2025, a high-level overview of the workforce and further work is underway to inter-relate and align financial planning to the workforce plan via the Strategic Planning Resource Allocation (SPRA) process using a template to collect both the workforce projections and the SPRA information. Workforce risks remain high across NHSScotland and indeed health

sectors all over the world and the current risk and target risk scores for Workforce within NHS Fife will require careful consideration to ensure they reflect local, national and international pressures and the extent to which these are and can be mitigated locally.

18. In the face of the challenges posed by Covid, maintaining operational performance against mandated targets has been almost impossible to achieve. It is likely that these challenges will continue and that operational improvements, whilst necessary, will only serve to buy time until genuine strategic solutions can be found, including closer working in partnership with the Integration Joint Board (IJB) to address underlying capacity and flow issues.
19. As reported in the Annual Internal Audit Report for 2021/22, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, with some subject to change. However the Board has continued to respond and risk assess to ensure the most urgent work is prioritised.
20. Whilst the SGHSCD has set a number of very challenging national objectives, many of which appear to be high risk, in terms of delivery, NHS Fife must set achievable strategic objectives which can be delivered within its own risk tolerances.
21. NHS Fife continues to progress its Risk Management Framework Improvement Programme. The Board's overall approach to risk management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework. A Risks and Opportunities Group has been established which aims to embed an effective organisational risk management framework and culture, including assurance mapping principles. Consideration of current risk scores and achievement of target scores by target dates will require constant monitoring to ensure they fully reflect current risk and controls and in particular, target scores must be realistic.
22. Governance and assurance processes for clinical activity undertaken in services provided by the IJB continue to evolve but are not yet fully agreed and in place to ensure that NHS Fife Clinical Governance Committee is assured appropriately and timeously. Assurance should be provided to the NHS Fife Clinical Governance Committee on inspection reports and on Child and Adult Protection risks.
23. We have made recommendations on provision of adequate and effective assurance to the Clinical Governance Committee (CGC), the Clinical Governance Oversight Group (CGOG) and the Organisational Learning Group (OLG) on effectiveness of internal control systems in identifying issues raised in external inspection reports, and on the management of clinical risks due to delayed treatment, and on the management of adverse events.
24. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to further enhance governance through the application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

- The reporting of the OPEL (Operational Pressures Escalation Levels) on the NHS Fife intranet, and the high escalation levels reported, reinforces the heightened risk environment both locally and across NHSScotland;
- Establishment of the Financial Improvement and Sustainability Programme Board early in 2022 to oversee Cost Improvement plans which will be required to support delivery of financial balance in the short and medium term;

- An interim update PAMS endorsed by the Finance, Performance & Resources Committee (FPRC) and approved by the NHS Fife Board in September 2022;
- Three year Financial Plan developed and approved by the NHS Fife Board in September 2022;
- Scottish Government (SG) approval, on 21 September 2022, of the Annual Delivery Plan (ADP) for 2022/23 and the development of a progress reporting tool to monitor delivery against the ADP;
- Ongoing enhancements to the Integrated Performance and Quality Report (IPQR) through the IPQR Review Group;
- Development of Risk Management arrangements including a Corporate Risk Register;
- Development of the Clinical Governance Strategic Framework with the final approval given by the Clinical Governance Committee in January 2023;
- The Staff Health and Wellbeing Framework, setting out the NHS Fife ambitions in respect of staff health and wellbeing, presented to the November 2022 Staff Governance Committee (SGC) for approval;
- The NHS Fife Workforce Plan 2022-2025 endorsed by the SGC and approved by the Board prior to submission to the Scottish Government for 31 July 2022;
- Whistleblowing directives issued by the Independent National Whistleblowing Officer are being implemented with NHS Fife.

25. Overall, there has been good progress on recommendations from the ICE from last year and the Annual Report for 2021/22. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

26. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

27. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1		
Update of Progress Against Outstanding Actions from previous ICE and Annual Reports		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
Annual Report 2021/22 – B06/23		
1 – Ministerial Steering Group (MSG) • A report on the MSG indicators will be presented to the Finance and Performance Committee. ***Original date of expected completion 30 September 2022.***	A report on the MSG indicators was not reported to FPRC in July, September, and November 2022, nor Fife NHS Board in July, August, September and November 2022. An update will be provided to the next FPRC meeting.	 **Significant Slippage**
ICE Report 2021/22 – B08/22		
1. Performance Reporting • As part of the Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls. • The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described. ***Original date 31 March 2022.*** **Revised Date 30 June 2022** **Further Revised Date March 2023**	The Corporate Risk Register and Dashboard paper was approved by Fife NHS Board in September 2022. This included proposals for: • A risk profile dashboard • deep dive reports • IPQR including the risk profile dashboard. The revised risk management development are now operational and interpreted within the IPQR. Presentation of the information is continusly reviewed with good evidence of the effectiveness of the 'Deep Dive' presented in the last 2 cycles of the Governance Committees.	 **Minor slippage on agreed timelines**
2.Organisational Duty of Candour (DoC) • An update on the number of instances Organisational Duty of Candour has been applied in NHS	The DoC annual report for 2020/21 included comparative information regarding the previous 2 years and this approach will continue in future.	 **Significant Slippage**

Fife in 2021/22 should be scheduled for presentation to CGC prior to conclusion in the Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow the CGC to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22. • The Committee should be told when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting. ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***	In addition, the SBAR supporting the 2021/22 DoC annual report (now scheduled for presentation to CGC in March 2023) will include commentary on 2022/23 activity to date and whether there are any issues with compliance that the CGC needs to be aware of. The timing of adverse event reviews means that this information will not be definitive, but it will provide CGC with the assurance available at that time ahead of it concluding on its own annual assurance statement. Proposal to extend to 31 March 2023 agreed by Medical Director.	
3.IPQR and Financial Sustainability BAF • Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed. • The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations. ***Action Owner:*** **Director of Finance and Strategy** ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***	The Corporate Risk Register and Dashboard paper was approved by Fife NHS Board in September 2022. This included proposals for: • A risk profile dashboard • deep dive reports • IPQR including the risk profile dashboard. The dashboard in the IPQR is to be further developed over the next 4 months and feedback from committee members used to decide whether it is an effective addition. Reporting on corporate risks in the risk profile dashboards, deep dive reports and the IPQR to FP&RC during the remainder of 2022/23, and the manner in which the revised reporting drives discussion at these meetings is key to the actions being considered completed. Therefore the target implementation date has been extended to 31 March 2023. Feedback from committee members has been noted and taken into consideration in the further development of the risk management framework.	 **Minor slippage on agreed timelines**

ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the SPRA as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***	The development of the NHS Fife Population Health and Wellbeing Strategy is ongoing. Fife NHS Board was updated in September 2022 on progress against the milestones previously presented to the Board in March 2022. This includes a target of December 2022 for a draft strategy to be ready for presentation to Fife NHS Board at their January 2022 meeting. The original target implementation date for this action was extended to 31 March 2023 and the update provided to Fife NHS Board in September 2022 indicates that this will be achieved.	 **Some Slippage**

CORPORATE GOVERNANCE

Corporate Risks:

Risk 1 – Population Health and Wellbeing Strategy – High Risk (12); Target (8) Moderate

There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.

Risk 2 – Health Inequalities – High Risk (20); Target (10) Moderate

There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.

Governance Arrangements

The Governance Structure update provided to the May 2022 Board meeting advised that the NHS in Scotland has formally stepped down from its emergency footing and is moving from remobilisation to recovery on a transitional approach. NHS Fife has set up an Executive Directors Group (EDG) huddle which will be kept under review with the possibility of re-establishing the Gold Command, or stepping down the EDG huddle depending on activity levels.

Board Development Sessions were held for a diverse selection of topics during 2022/23, including Clinical Strategy, Equality and Diversity, Cyber Security, role of the Assistant Practitioner, Integrated Planned Care Elective Recovery and Culture, Values and the Role of the Board and Risk Management. Given the importance of these sessions and to ensure their value is maximised, consideration should be given to formal outputs from Board Development Sessions and action plans to ensure any agreed decisions/actions are taken forward.

Whilst there has been significant progress locally, it is unfortunate that delays in proposed national governance initiatives have inhibited the Board's ability to undertake local improvement and assessment work on Board governance.

Committee Assurance

The Terms of References were reviewed by the respective standing committees and a revised Code of Corporate Governance formally approved at the July 2022 Board meeting.

Each Standing Committee has an Action List to ensure any actions from previous meetings are followed up. However, the Board Action List is administered by Corporate Services and should be presented as a standing item to each Board meeting.

The previous action plan for the Blueprint evaluation was reported to the Board in January 2022, with all actions reported as completed. Further national iterations of the Blueprint are awaited.

Policies

A General Policies and Procedures update was provided to the November 2022 meeting of the Finance Performance & Resources Committee (FPRC). 46% (26 /57) of polices are up to date, with 5 currently going through formal approval. The risk section of the SBAR - General Policies and Procedures, did not articulate the risks to NHS Fife of these policies not being up to date. We are also aware of superseded policies remaining on Stafflink which could lead to confusion.

Culture and Values

A Board Development Session in April 2022 focussed on the culture and values of NHS Fife. The NHS Fife Code of Corporate Governance includes references to culture and values and we have seen

examples of the Board and its officers promulgating these values. However, there is further scope to ensure Committee and Board papers reflect and promote these values and assess whether the desired culture is in place.

Strategy

As highlighted within B06/23 Annual Internal Audit Report 2021/22, the process for developing the Population Health and Wellbeing Strategy was approved at the 29 March 2022 Board meeting. The Board has been regularly informed on the development of the Strategy with assurance papers presented to the May, July, September and November 2022 Board meetings and to a Board Development Session in April 2022. The SBAR to the September Board meeting provided an update (to 22 August) on the Milestone Plan and provided assurance that the Population Health and Wellbeing Strategy is aligned with the National Care and Wellbeing Portfolio. The draft Strategy and associated Delivery plan is to be presented to the NHS Fife Board by January 2023.

We note an update on the existing Clinical Strategy 2016-2021 is to be presented to the 29 November 2022 Board meeting.

The Public Health and Wellbeing Committee (PHWC) has oversight of the development of the strategy with the Portfolio Board established to commission and monitor the delivery of key milestone activity related to the delivery of the new strategy. The Portfolio Board reports to the PHWC. The Corporate Risks aligned to the PHWC along with the Assurance Principles were considered at the November 2022 meeting.

On 14 November 2022, the Scottish Government outlined its planning approach for 2023-24 which stated an intention to have a more co-ordinated and coherent approach to delivery planning across the whole system. This new planning approach will include:

- clear, high level, population based priorities for the NHS as a whole
- goal setting at national level
- continuation of short, medium and longer term planning by Boards
- a new commissioning approach which will engender greater collaboration to reflect Scotland's population needs as a whole in local, regional and national plans.

Further guidance will be issued in February 2023, including articulation of national priorities which will form the basis for the strategic 'commission' for Boards' own plans. The extent to which these national priorities will be achievable within the constraints under which NHS Fife operates and also the extent to which they match identified local population needs, will not become clear until then.

Internal audit B14/23 Strategic Planning, will further evaluate the development of the Strategic Plan, including an assessment of whether it is likely to deliver services which are sustainable within key constraints, most notably workforce and finance. We will also be issuing a similar assessment of the Fife IJB Strategic Plan, which will inform NHS Fife's Strategic priorities and direction.

Operational Planning

The draft Annual Delivery Plan 2022-23 is in line with Scottish Government guidance and was presented to the Board in July 2022 before submission to the Scottish Government by the end of July 2022 and subsequent approval by the Board in September 2022.

We commend the Operational Pressures Escalation Levels (OPEL) tool, developed within NHS Fife and introduced to help provide consistency in reporting and the defined levels of action points linked to the OPEL score and escalation in response to key triggers with the process, roles and responsibilities defined. The OPEL tool is published on a daily basis on Stafflink for organisational awareness and has shown the extreme pressures within the system and the high risk environment the Board is currently operating within.

Assurance Mapping

The Committee Assurance Principles were endorsed by the NHS Fife Audit & Risk Committee (A&RC) in May 2021. A development session is planned for the A&RC in February 2023, which will discuss how to roll out these principles further within NHS Fife. The Board Secretary is currently working with Standing Committee Chairs to ensure they continue to be embedded within the Board's formal assurance processes

Internal Audit will continue to promote the use of the assurance principles through continued leadership of the Assurance Mapping Group, attendance at the Risks and Opportunities Group and though individual Internal Audits.

Integration

The Integration Scheme was reviewed and approved by the NHS Fife Board in September 2021. A MSG self-assessment update was provided to the April 2022 meeting of the Fife IJB A&RC. Two areas were identified for further investigation with all other actions having planned completion dates. An update on MSG recommendations has still to be presented to the FPRC, as agreed in the Annual Internal Audit Report for 2021/22.

The SBAR supporting the Board Assurance Framework presented to the September 2022 A&RC stated that the IJB component of the BAF was discussed at the EDG meeting on the 16 June 2022 and, in light of the review of the Integration Scheme and strengthened governance arrangements, a decision was made to close this risk, with any residual elements included within the new Corporate Risk Register.

Performance

Enhancements to the IPQR continue to be progressed through the IPQR Review Group. An update was provided to Fife NHS Board on 29 March 2022 on the format of the IPQR and consideration of which metrics are to be included within IPQR in 2022/23 was undertaken by the FPRC on 12 July 2022. We commend the ongoing commitment to improving the presentation of the IPQR including enhancement of the performance risk section, further information on adverse events and information on the Establishment Gap.

Covid-19 vaccinations and uptake of flu vaccination will be included in the IPQR. The enhanced IPQR should negate the requirement for separate reports on these topics in the future.

The Board, the FPRC, the SGC, the CGC and the PHWC have received regular performance reports against a range of key measures (Scottish Government and local targets). Projected & Actual Activity for Patient TTG, New Outpatients and Diagnostics are also reported.

The latest IPQR presented at the September 2022 Board meeting highlighted:

- There were no breaches against the 31-Day Cancer Diagnostic Decision to first Treatment measure and performance has been above the Standard for the last 26 months. Performance against the 62-day Cancer Standard fell slightly in comparison to May to 84.5% with a target of 95%.
- Antenatal are meeting target, with three indicators not achieving target but performing within the upper quartile within benchmarking: Delayed discharge % Bed Days Lost (Standard); Patient TTG %<=12 weeks and C Diff HAI/HCAI.
- Twelve indicators are not achieving target but are performing within the Mid Range quartile for benchmarking: 4- Hour Emergency Access; Cancer 62 Day RTT; 18 Weeks RTT; New Outpatients; Diagnostics; Detect Cancer Early; ECB – HAI/HCAI; Complaints Closed Stage 2; Sickness Absence; Smoking Cessation; CAMHS Waiting Times and Psychological Therapy Waiting Times. The waiting lists for New Outpatients had an increase of 16% when compared to the previous year, and TTG waiting lists increased by 53%.

- The Projected Activity compared against Actual Activity within New Outpatients and Diagnostics was higher than the forecast and TGG activity was approximately 6% lower than forecast.

Clearly performance against a range of targets is proving challenging for NHS Fife, in common with the entirety of NHSScotland and it is imperative that NHS Fife is able to set and deliver realistic targets, within the context of its new Strategic Framework, as soon as possible.

Risk Management

The Risk Management Improvement Programme has continued with an SBAR update of the programme presented to the September 2022 meeting of the A&RC.

The Board considered its risk appetite pre-pandemic in 2019 and a revised risk appetite statement was considered at a Board Development Session in June 2022, with approval by the Board on 26 July 2022.

Following engagement with the EDG, Senior Leadership Teams and the Board, a Corporate Risk Register (CRR) has now been developed, with the initial presentation of the CRR to each of the standing committees in November 2022, and formal approval at the 29 November 2022 NHS Fife Board meeting.

The Director of Finance and Strategy informed the September Board that *'the CRR is a dynamic document which requires further refinement'.* CRR papers to standing committees in November 2022 were significantly improved and included the Assurance Principles. This should, in future, allow much greater scrutiny of and focus on the risk and target scores within the revised CRR and greater overt consideration of the effectiveness and impact of mitigating actions and controls. We did note some a number of risks where achievement of the target score in the stated timescale would be exceedingly challenging.

Key Performance Indicators still require further development, to allow the A&RC to oversee performance management of the risk management framework. As the framework evolves we would expect risk appetite to be overtly reflected, particularly within target scores, when risks are updated and reviewed.

A risk escalation process was considered by the EDG on 18 August 2022 and the newly established Risks and Opportunities Group (ROG) will take this forward as part of its remit. The ROG's purpose is to provide leadership and promote and embed an effective risk management culture. The group held its initial meeting on 14 September 2022, and is co-chaired by the Associate Director of Quality and Clinical Governance and the Associate Director of Digital & Information. A Terms of Reference has been developed and the group will report to the EDG.

Internal Audit attend the ROG and will input accordingly, with a focus on embedding the assurance principles within the risk processes. A full Internal Audit review of the risk management arrangements, with further exploration of some of the issues identified within this section, will be completed before year-end.

Action Point Reference 1 – Committee Assurances

Finding:

We have noted some areas where there is further scope to enhance governance arrangements:

a) The Board has an Action List which is administered by Corporate Services and is not presented at Board meetings;

b) The risk section of the SBAR papers presented to the Standing Committees still do not always articulate risks and possible consequences associated with the paper;

c) The General Policies and Procedures update provided to the November meeting of the FPRC, reported a significant number of policies which are out of date and, in particular, a number of Staff Governance policies that had surpassed their review date, but did not articulate the associated risks. Superseded policies remain on Stafflink.

Audit Recommendation:

We recommend that:

a) The Action List is presented to the Board as a Standing Agenda Item, in line with good practice;

b) The risk section within the SBAR papers presented to the Standing Committees and the Board should fully articulate the risks associated with the report, the linkage to the relevant Corporate or Operational risk and any related consequences;

c) Future SBARs on Policy updates should include a risk assessment on each policy which has passed its renew date, which highlights the risks and possible consequences of the policy not being reviewed within the timescale. Superseded policies should be removed from Stafflink.

Assessment of Risk:

Merits attention

There are generally areas of good practice.
Action may be advised to enhance control or improve operational efficiency.

Management Response/Action:

a) It is agreed that the Board's action list, which is currently maintained and followed up by the Corporate Governance & Board Administration team, will be tabled for review at future Board meetings.

b) A new SBAR template for EDG and the Board was released in October, which gives strengthened guidance, including within the risk section, covering the areas cited in the recommendation. It is anticipated this will assist authors in providing the information highlighted.

c) Staff Governance policies are not included within the General Policies update to FPRC, as these are reported separately by the Workforce Directorate to the Staff Governance Committee. It is agreed that further information will be given in future iterations of the FP&R report to highlight any specific risks from General Policies being beyond their due date.

A programme led by the Webteam is currently underway to remove General Policies from StaffLink, replacing these with a link to the relevant documentation hosted on the NHS Fife website. This will avoid any unnecessary duplication of versions across more than one site and ensure that any out-of-date versions are removed promptly once superseded. In terms of HR Policies, the review cycle is overseen by the HR Policies Group and any risks relating to outstanding review work would be fed back to Staff Governance Committee as part of the annual reporting cycle. As part of this work we note the impact of national 'Once for Scotland' policy review activity.

Action by:	Date of expected completion:
Head of Corporate Governance & Board Secretary	**June 2023**

Action Point Reference 2 – Risk Management	
Finding:	
Corporate Risk Register papers to standing committees in November 2022 were significantly improved and included the Assurance Principles. This should, in future, allow much greater scrutiny of and focus on the risk and target scores within the revised CRR and greater overt consideration of the effectiveness and impact of mitigating actions and controls. We did note some a number of risks where achievement of the target score in the stated timescale would be exceedingly challenging.	
Audit Recommendation:	
Key Performance Indicators still require further development, to allow the A&RC to oversee performance management of the risk management framework. As the framework evolves we would expect risk appetite to be overtly reflected, particularly within target scores, when risks are updated and reviewed.	
Assessment of Risk:	
Merits Attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
KPIs will continue to be developed and will will be presented for approval by June 2023.	
Action by:	**Date of expected completion:**
Director of Finance	**30 June 2023**

CLINICAL GOVERNANCE

Corporate Risks:

Risk 3 – COVID-19 Pandemic – High Risk (16); Target (12) Moderate

There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease, including death in a minority of the population.

Risk 5 - Optimal Clinical Outcomes – High Risk (15);Target (10) Moderate

There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium term.

Risk 7 - Access to Outpatient, Diagnostic and Treatment Services - High Risk (16);Target (12) Moderate

There is a risk that due to demand exceeding capacity, compounded by COVID-19 related disruption and stepping down of some non-urgent services, NHS Fife will see a deterioration in achieving waiting time standards. This time delay could impact clinical outcomes for the population of Fife. [Aligned to FP&RC]

Risk 9 - Quality & Safety – High Risk (15);Target (10) Moderate

There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service – Moderate Risk (12);Target (6) Low

There is a risk that by continuing to use a single offsite service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.

Clinical Governance Framework

The draft Clinical Governance Strategic Framework (CGSF) and associated annual delivery plan for 2022/23 were approved by the NHS Fife Clinical Governance Committee on 4 November 2022 and we are advised that finalised versions were presented to CGC in January 2023. The CGSF has been developed with contribution from key stakeholders across NHS Fife. The strategy includes elements that address recommendations made in our report on Clinical Governance Strategy and Assurance (B19/21), although we did note that some of our recommendations were not completely addressed either in the framework or through other agreed actions such as adjusting workplans and ToR. Management have been informed of the detailed omissions via the internal audit follow-up system.

The Annual Delivery Plan references 18 separate workstreams at different stages of completion. Work on establishing an Organisational Learning Group, reviewing the Clinical Governance Oversight Group, Development of an Acute Services Division Quality report and on embedding processes for the reviews of deaths of children and young people are reported as complete. Implementation of

the delivery plan is to be monitored by the Clinical Governance Oversight Group.

The papers presented to CGC with the CGSF included a paper on Health and Social Care Partnership (HSCP) Clinical and Care Governance and Assurance Arrangements. These are now reflected in the CGSF. These proposals are considered in more detail within our draft report to the IJB on their Clinical and Care Governance arrangements (F06/22) a summary of which will be presented to the NHS Fife ARC as part of the information sharing protocol.

We would highlight that the Framework states that '*Any direction issued by the IJB must meet all clinical and care governance requirements and standards to ensure patient safety and public protection as well as ensure staff and financial governance. Every IJB has senior professional, clinical and financial advisors as part of their core membership to provide scrutiny of these aspects and to provide assurance. This does not require to be remitted for additional checking through Local Authority of Health Board systems: Local Authorities and Health Boards should ensure that the professional and clinical advisors tasked to provide advice to IJBs are appropriately experienced and supported in their role'.* It is therefore imperative that the Health Board is assured that staff working in the IJBs are aware of this key responsibility and of the need to consult with relevant Health Board staff where there are issues of significant clinical concern.

Section 6.2d of the standing orders of Fife NHS Board states that the strategies for all the functions it has planning responsibility for are a matter reserved for the Board therefore the CGSF, once finalised and endorsed by the CGC, should be presented to Fife NHS Board for approval.

The Framework does not state how it will relate to the Population Health and Wellbeing Strategy currently being developed, however, it is aligned to the same strategic framework document and therefore should not require substantial revision once the PHWS is approved.

Clinical Governance Committee

The CGC Terms of Reference (ToR) included in issue 19 of the CoCG approved by Fife NHS Board on 26 July 2022 included additions related to clinical governance aspects of the developing Population Health & Wellbeing Strategy and alignment and oversight with the emerging Programmes reporting through the Portfolio Board.

The CGC annual workplan for 2022/23 is presented to each CGC meeting and is updated to show items considered as planned and any deferred to later dates. The latest presentation of the workplan indicates that CGC should receive all items in 2022/23 with the exception of Annual Assurance Report and Statements for the following committees and groups, which were missing from the workplan:

- IJB Quality and Communities Committee
- Health and Safety Sub-Committee
- Information Governance & Security Steering Group.

As noted above, not all agreed actions from B19/21 have been implemented.

Clinical Risk Management

The four corporate risks detailed at the start of this section have been aligned to the CGC, as have 2 Information Governance risks .

We will consider the papers presented to CGC during the remainder of 2022/23 to determine whether the new deep dive reports and enhanced scrutiny at CGC meetings allows the CGC to provide reasonable assurance on these risks at year-end, including accuracy of scores, adequacy and effectiveness of key controls and key actions.

The CGC has not received any assurance in 2022/23 to date regarding the Adult and Child Protection risk recorded in the IJB strategic risk register.

We also noted that the description of the risk titled 'Optimal Clinical Outcomes' (Risk 5) does not fully describe the risk associated with deferred treatment due to the pandemic, does not reflect on any additional risks posed by the requirement by the SG to treat the least clinically urgent cases and the scoring of this risk does not appear to be realistic in the current circumstances.

Clinical Performance Reporting

The latest IPQR and supporting presented to CGC on 4 November 2022 highlighted the following areas which are not reaching target:

- Pressure Ulcers
- ECB (HAI/HCAI)
- CDiff (HAI/HCAI)
- Complaints (S1 & S2)

The IPQR SBAR notes:

- '*As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2022/23. These are a 10% reduction on the FY 2021/22 target for Falls, and a 25% reduction on the actual achievement in FY 2020/21 for Pressure Ulcers.*
- *Ongoing challenges relating to Covid and staffing levels within the Patient Relations Department has meant that closure performance of Stage 2 Complaints fell 2/4 significantly during FY 2021/22. An improvement target of 50% by March 2023, rising to 65% by March 2024 has been agreed by the Director of Nursing'*.

The IPQR now includes the relevant corporate risk within each performance section.

External Review

While External Inspection Reports are included on an Activity Tracker document routinely considered by the Clinical Governance Oversight Group (CGOG), the CGOG Terms of Reference do not include responsibility for consideration of external review outcomes and whether appropriate action has been undertaken to address any recommendations made.

The Activity tracker documents presented to CGOG in 2022/23 did not include reports from the Mental Welfare Commission regarding inspections in wards at Lynebank, Queen Margaret, Whyteman's Brae and Stratheden Hospitals, which were however reported to the IJB's Quality Matters Assurance Group. Whilst these reports did not contain any significant matters of concern, this highlights a potential gap in assurance provision to the NHS Fife CGC on recommendations made in external inspection reports related to services delegated to the IJB, which will need to be addressed, avoiding unnecessary duplication.

The recently established Organisational Learning Group (OLG) has met on 4 occasions to date in 2022/23. The remit of the group is focussed on identifying lessons and good practice that can be shared across the organisation and on identifying the best communication methods for this. However, whilst they are fulfilling many aspects of their remit, the group has not yet used issues identified in external reports to assess the adequacy of internal assurances, although this was an agreed Internal Audit recommendation. In addition, the process for triangulating data to assess whether the internal control framework is functioning effectively is not referred to in the CGSF or the SAER process.

Significant Adverse Events

A full review of the Adverse Events Policy and Procedures is being undertaken with a target timescale for publication of January 2023 for a revised Adverse Events Policy and June 2023 for the related Procedural document. A test of change has been introduced to the executive review and approval process for SAER to alleviate the time constraints on the review teams and to make the overall process more efficient. It is anticipated that this change will allow focused time on clearing

the backlog of overdue SAER's. .

The Key Performance Indicator (KPI) information provided to CGOG on 18 October 2022 highlighted that over half of open SAERs Significant Adverse Event Reviews (SAERs) had exceeded the 90 day target for completion.

Implementation of actions identified from SAERs is to be added to the IPQR from December 2022 as a metric to provide overview and assurance. The average number of actions closed within the target timeframe over the last 12 months is 51%. An improvement target will be set out in the IPQR to achieve 70% closure rate and this target will be reviewed annually.

The poor performance in processing SAERs was not escalated by CGOG to CGC.

Duty of Candour (DoC)

The DoC Annual Report for 2021/22 is now scheduled for presentation to CGC in March 2023. We have recommended in internal audit B08/22 that the SBAR supporting this report should include all known information on DoC activity in 2022/23.

Action Point Reference 3 – Clinical Governance and Assurance re Services Delegated to the Integration Joint Board

Finding:

We identified the following examples of assurance processes associated with services delegated to the IJB are not operating in a manner that would provide CGC with timely assurance on clinical issues and risk management in these services:

- The Activity tracker documents presented to CGOG in 2022/23 to date have not included reports from the Mental Welfare Commission regarding inspections in wards at Lynebank, Queen Margaret, Whyteman's Brae and Stratheden Hospitals which were, however, reported to the IJB's Quality Matters Assurance Group (QMAG)
- The Clinical Governance Committee has not received any assurance in 2022/23 to date regarding the Adult and Child Protection risk recorded in the IJB strategic risk register (Risk 10).

Audit Recommendation:

A process should be established, avoiding unnecessary duplication, to ensure that CGOG is provided with assurance that appropriate action is being undertaken to address recommendations made by external bodies in relation to their inspections of services delegated to the IJB.

The NHS Fife Clinical Governance Committee should be provided with assurance regarding the management of risks associated with Adult and Child Protection and should be updated on how the latest Scottish Government's NHS Public Protection Accountability and Assurance Framework is to be used in mitigation of the risks.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

<u>CGOG Assurance Regarding Addressing Recommendations made by External Bodies</u>

Inspections are currently a standing agenda item on the Health and Social Care Partnership Quality Matter Assurance Group's workplan.

An overview report on visits, recommendations and actions will be provided to the Clinical Governance Oversight Group (CGOG) for the April Meeting, thereafter regular update reports will be provided at each CGOG to give assurance that recommendations made following external body visits are being progressed through service action plans to completion. Services will be expected to review and risk assess inspection recommendations and process and manage these appropriately.

A key aspect of future service action plans will include a considered review for wider learning which can then be shared across other clinical areas.

Reports on Inspections will be added to the CGOG workplan.

Assurance to CGC Regarding Risks Associated with Adult and Child Protection **This risk was closed in July 2022 by, Risk Compliance Manager - Fife Health and Social Care Partnership. However, the risks stated are being reviewed, those refreshed risks and mitigations will be reported to the Clinical Governance Oversight Group in July.**	
Action by:	**Date of expected completion:**
Director of Fife Health and Social Care Partnership	**April 2023**

Action Point Reference 4 – Clinical Governance Strategic Framework & Clinical Governance Risk Management

Finding:

Clinical Governance Strategic Framework

The CGSF has not yet been scheduled for presentation to Fife NHS Board for approval and does not cover Adult and Child Protection or the latest guidance (Scottish Government's NHS Public Protection Accountability and Assurance Framework)

Clinical Governance Oversight Group (CGOG)

The Terms of Reference for CGOG do not include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made.

Organisational Learning Group (OLG)

The OLG has not yet fulfilled its responsibility to consider issues identified in external reports and determining whether the issues were identified by internal control systems, before they were discovered by an external auditor/regulator, and what needs to change as a result (this responsibility was included in the OLG remit in response to a previous internal audit recommendation). We also noted that the minutes of OLG meetings are not being presented to CGOG as per the OLG ToR.

Management of Clinical Risk

From the risks aligned to the CGC the description of the risk titled Optimal Clinical Outcomes (Risk 5) does not fully reflect the risks associated with deferred treatment and the scoring of this risk and the associated target risk require further consideration to ensure they are realistic. We are aware that risk 7, which is aligned to the Finance, Performance and Resources Committee further articulates the risksassociated with deferred treatment but the description of the risk needs to be reviewed to ensure that it conveys the gravity of the situation.

Adverse Events Management Assurance

The poor performance in processing SAERs has not been specifically escalated by CGOG to CGC.

Examples of issues with performance, as of the end of November 2022, are:

- 53% of Major/Extreme incidents closed within 90 days
- Only 42% of LAER and SAER actions closed within target date.

As of January 23rd 2023:

- 28 of 47 SAERs were over the 90 day target for investigating and reporting

Audit Recommendation:

Clinical Governance Strategic Framework

Section 6.2d of the standing orders of Fife NHS Board states that the strategies for all the functions it has planning responsibility for are a matter reserved for the Board therefore the CGSF once finalised should be presented to Fife NHS Board for approval.

The CGSF should be updated to specifically refer to:

- Adult and Child Protection and the latest guidance (Scottish Government's NHS Public

Protection Accountability and Assurance Framework).

Clinical Governance Oversight Group (CGOG)

The CGOG ToR should be amended to include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made.

Organisational Learning Group (OLG)

In the remainder of 2022/23 an OLG meeting should be focussed on this topic (ie how to build in the consideration of issues identified in external reports into future OLG agendas and the analysis that would need to be undertaken to provide the OLG with the information to discharge their responsibility as per its ToR item 2.4 – '*Analysis of internal control systems to identify why these did not identify the issues highlighted by the external reports to allow changes to be made so that these issues are highlighted internally earlier in the future*'). The group should consider whether Internal Audit input at this meeting would be beneficial.

Minutes of OLG meetings should be presented to CGOG routinely.

Management of Clinical Risk

The description of risk 7 - Access to outpatient, diagnostic and treatment services should be updated to more accurately describe the risk associated with deferred treatment due to late presentation due to the pandemic (eg changing the '***could***' in '*This time delay **could** impact clinical outcomes for the population of Fife*' to '***will***'). and the scoring of this risk should be revised to take account of the related performance information.

The anticipated deep dive analysis to be undertaken on risk 7 should be prioritised and should be undertaken in a manner that clearly explains the scale of the risk and better describes the controls in place. The alignment of this risk should also be reconsidered as it is important that the members of the CGC understand totality of the risk and associated controls and assurances.

Adverse Events Management Assurance

The difficulties in meeting SAER targets should be reported to CGC.

Assessment of Risk:

Merits attention

There are generally areas of good practice.
Action may be advised to enhance control or improve operational efficiency.

Management Response/Action:

<u>Clinical Governance Strategic Framework</u>

Having considered the fact that the CGSF doesn't specifically reference the impact of deferred treatment due to Covid-19 and how this will impact upon the clinical care provided it was decided that this level of detail wasn't appropriate for the Framework document and instead would be considered as part of the 2023/24 workplan. This is also part of our corporate risks and considered also through this route to clinical Governance.

Having considered including a reference to Adult and Child Protection within the Framework and the latest guidance thereon (Scottish Government's NHS Public Protection Accountability and Assurance Framework again it was felt that this was a level of detail that would not sit within the Framework itself but would be considered as part of the 2023/24 workplan.

It was felt that there was adequate detail within the Framework explaining the process in assessing whether the Framework was functioning adequately.

Clinical Governance Oversight Group (CGOG)

The Terms of Reference will be reviewed with a view to amend and include the requirement of CGOG to give consideration of external reviews and consider whether appropriate action has been undertaken to address any recommendations made.

Organisational Learning Group (OLG)

The OLG is at a very early stage of development and not yet at a stage to consider issues identified in external reports and determining whether the issues were identified by internal control systems. A change of personell this has also slowed the progress.

Management of Clinical Risk

The Assocaite Director of Quality and Clinical Governance will discuss risk 7 with the owner of the risk (Director of Acute Services) to consider the wording along with consideration of the need for CGC to receive assurance on this risk. We will also ascertain the timescale for risk 7 to undertake a deep dive and seek to prioritise this.

Adverse Events Management Assurance

A test of change has been introduced to the executive review and approval process for SAER to alleviate the time constraints on the review teams and to make the overall process more efficient. It is anticipated that this change will allow focused time on clearing the backlog of overdue SAER's. This will be a reviewed at the end of February.

Figures as of the end of November 2022, are:

- **53% of Major/Extreme incidents closed within 90 days**
- **Only 42% of LAER and SAER actions closed within target date.**

As of January 23rd 2023:

- **28 of 47 SAERs over the 90 day target for investigating and reporting**

Emerging issues with delays in the SAER process has been regularly escalated to CGOG for discussion. Initial discussions resulted in the presentation and discussion on a SAER/LAER 5 year synopsis paper which identified some of the key issues. Immediate changes to the Executive sign off process as described above were introduced to alleviate time pressures on the review teams.

Action by:	Date of expected completion:
Medical Director	August 2023

STAFF GOVERNANCE

Corporate Risks:

Risk 11 - Workforce Planning and Delivery – High Risk (16); Target (8) Moderate

There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.

Risk 12 - Staff Health and Wellbeing – High Risk (16);Target (8) Moderate

There is a risk that if due to a limited workforce supply and system pressures, we are unable to maintain the health and wellbeing of our existing staff, we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.

Governance Arrangements

The SGC approved revised Terms of Reference in March 2022 and the revised CoCG was approved by the Board at its July 2022 meeting. Updates on the stage of completion of the 2022/23 SGC workplan are now being reported to each SGC.

While SGC assurance reports to Board do not highlight key risks on Personal Development Plan Reviews (PDPR) completion and completion of training, this risk is reported within the IPQR. To enhance the process and demonstrate triangulation, the SGC Assurance report should highlight any issues, irrespective if they are included within other reporting mechanisms to the Board.

Workforce Strategy/Planning

In compliance with the SG requirements to re-introduce a 3 yearly planning cycle across NHS Scotland, a NHS Fife Workforce Plan 2022-2025 has been produced and published in November 2022. The deadlines were met for SGC endorsement and Board approval of the plan before submission to the Scottish Government by 31 July 2022. Internal Audit has completed a review of the plan and will comment on it in detail within the B17/23 – Workforce Planning report, which will be presented to the SGC once finalised.

Risk Management

The SGC will now review corporate risks for Workforce Delivery & Planning and Staff Health & Wellbeing, both of which have a current high rating. Our assessment is that the initial corporate risks report provided to the SGC in November 2022 did not provide sufficient detail on the mitigating actions to enable members to conclude on the current risk scores and the likelihood of the target scores being achieved. The current target reduction from high to moderate for both risks by the end of March 2023 is highly ambitious in the current circumstances.

Staff Governance Standards

Guidance is still awaited from the SG review on staff governance standard monitoring arrangements and accordingly there was no requirement to prepare a staff governance action plan (SGAP) for 2022/23. A number of positive measures are being introduced during 2022/23 to provide the SGC with more detail on the initiatives to meet the SGSs. This includes reports on work undertaken to meet each strand of the SGS within the SGC workplan for 2022/23. At the BDS on 24 October 2022, a presentation gave an overview of the mechanism by which NHS Fife implements and monitors compliance with the SGS. The mechanism is considered by NHS Fife to provide a sound framework for monitoring compliance with the standard, but it does not provide details of the planned initiatives or a measure of how successfully and effectively they are being implemented.

Completion of the 2022/23 SGC Workplan (to date) was reviewed and it was noted that individual reporting to the SGC on each strand of the SGS is planned for 2022/23. However the dates for

reports on two strands (Well Informed and Involved in Decisions) has still to be confirmed.

An update was given to the November 2022 SGC meeting on developing and maintaining local HR policies and also those that fall within the scope of the Once for Scotland Workforce Policies programme (restarting in June 2022). Details of forthcoming reviews were provided, with an overall summary on the maintenance of local policies within NHS Fife.

Staff Experience

The ongoing impact of the Covid-19 pandemic has continued to be reported to the SGC in reports covering staff health and wellbeing, providing assurance on the action being taken to support staff. The Annal Delivery Plan 2022/23 which has workforce implications, was approved at the September 2022 SGC meeting. An update on its completion, including a summary of the completion of high level deliverables was presented to the November 2022 SGC meeting and 65% were reported as on track or complete. An improvement in the uptake of iMatters survey by staff for 2021 - 59% NHS Fife and 61% H&SCP – was reported to the November 2022 SGC meeting.

Whistleblowing

A review of NHS Fife's whistleblowing arrangements is being completed as part of the 2022/23 Annual Internal Audit Plan. At present the work completed indicates that NHS Fife is taking steps to fully implement the directives of the Independent National Whistleblowing Officer. Quarterly and annual reporting on the number of whistleblowing instances and subsequent investigation and implementation of lessons learned forms part of the SGC annual Workplan. Internal Audit B17/23 will be presented to the SGC for consideration.

The SGCs Annual Statement of Assurance for 2021/22 gives a detailed summary of the implementation of whistleblowing arrangements since they were introduced in April 2021. However, although the details of further developments still to be made to current whistleblowing arrangements are noted, an overt opinion on the adequacy of existing whistleblowing arrangements was not included. Providing the annual whistleblowing report to coincide with the issue of the SGCs Annual Statement of Assurance, as supported by a concluding statement from the Whistleblowing Champion, would enable the SGC to provide an overt opinion on the adequacy of whistleblowing arrangements for each year end.

Remuneration Committee

The Remuneration Committee (RC) reviewed its terms of reference at its April 2022 meeting and completed a self assessment of its performance, with only a small number of minor changes arising. Formal guidance and a standardised template on the format of standing committee terms of reference is still awaited from the Once for Scotland team.

Appraisals

The RC reviewed the completion of the 2021/22 performance appraisal process for the Executive and Senior Manager Cohort at its May 2022 meeting. It approved the 2022/23 objective setting process for the Executive and Senior Management Cohort at its July 2022 meeting.

The completion of annual AfC appraisals as reported to the SGC in November 2022 is still being impacted by the Covid-19 pandemic, with 33% of appraisals being completed at 31 October 2022. This is a marginal improvement on the 30% completed as at 31 March 2022. The SGC was advised that appraisal performance is being monitored and actions to support staff engagement continue in order to increase the focus on this process and sustain improvement. However, this issue was not escalated to the Board in the Committee Assurance Report. This was also highlighted in the latest SGS update where Appropriate Training and Development was identified as an area of required improvement.

The Annual Report on Medical Consultant and GP appraisals for 2021/22 was presented to the

November 2022 SGC meeting. It shows that 80% of Medical Consultants and 92% of General Practitioners had completed appraisals. The appraisal process was reported as recovering well from the impact of the Covid-19 pandemic, with the main challenges being getting sufficient appraisers and also evidential feedback from patients.

Core Skills Training

Obtaining reliable data on core skills training, which NHS Fife is required to deliver to its workforce in order to meet either legal training requirements or to comply with key quality standards in accordance with organisational policy and regulatory requirements, has previously been problematic. No overall reports on core training are currently available. Implementation of Phase 2 of TURAS Learn (replacing Learnpro) is expected to go live towards the end of 2022. It will record the staff training completed and thereby enable the completion rate to be reported in future.

Sickness Reporting

Sickness absence is now reported to the SGC on a regular basis through the Promoting Attendance update reports, which detail the work currently being undertaken by the Attendance Management Taskforce and Operational Group towards improving attendance and wellbeing. This is supplemented by summary data being included in the IPQR presented to each SGC meeting. The absence rate at 31 August 2022 was 6.50%. This is expected to rise further in future months with the removal of the temporary Covid-19 absence policy at 1 September 2022. As at August 2022 Covid-19 contributed an additional 0.98% to absence levels.

Action Point Reference 5 – Staff Governance Standard	
Finding:	
The mechanism for implementing the SGS as presented to the October 2022 BDS is considered by NHSF to provide a sound framework for monitoring compliance with the standard. However, it does not provide robust assurance of the planned initiatives or a measure of how successfully and effectively they are being implemented. We note in particular the very low rates of Turas completion and the associated risk that staff are not appropriately managed and trained.	
Audit Recommendation:	
As part of the March 2023 year end SGSs overview included in the 2022/23 SGC Workplan, a listing detailing the work still outstanding from 2022/23 to meet the different strands, for completion in 2023/24 should be presented to the SGC. The listing should also include the additional work planned for 2023/24. This will enable the SGC to assess the work completed during 2022/23 and approve the work schedule for 2023/24.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
An overview of the completion of work related to the Staff Governance Committee Workplan will be incorporated into end of year reporting for presentation back to Committee to assess work completed and inform work for 2023/24.	
Action by:	**Date of expected completion:**
Director of Workforce	**May 2023**

Action Point Reference 6– Staff Governance Standard	
Finding:	
As the final quarter of 2022/23 approaches, planned reporting on all strands of the SGS to the SGC may not be achieved. Dates for reports on the Well Informed and Involved in Decisions strands are still to be confirmed.	
Audit Recommendation:	
Dates should be set as soon as possible for those strands of the SGS which are not yet confirmed to ensure that the SGC will be able to reach an informed conclusion on compliance with the SGS in its annual report and assurance statement.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The change to Staff Governance Committee reporting in the course of 2022/23 has ensured reports to Committee are explicitly aligned to the Staff Governance Standard strands. Since the change was introduced in September 2022, reports on Well Informed and Involved in Decision Making have been presented on numerous occasions and the Committee considered a partnership presentation on the Staff Governance Standard in October 2022, which provided members with work currently being undertaken against all of the strands. The Committee has been presented with Local Partnership annual reports from Health & Social Care Partnership and Acute & Corporate Services in September 2022 and November 2022 respectively, which provided the Committee with updates on work across service areas related to Well Informed and Involved in Decision Making elements of the Standard. In addition, the Staff Governance Annual Monitoring return response to Scottish Government presented in November 2022 and iMatter National report presented in January 2023 provided information to the SGC members on feedback against the Standard and staff views aligned to these specific Staff Governance strands. Reflections on the adjustments to reporting, LPF annual reports, Staff Governance Monitoring exercise and iMatter feedback will be considered as part of year end assurance reporting and will inform the 2023/24 SGC Workplan to ensure effective consideration of all strands of the Staff Governance Standard.	
Action by:	**Date of expected completion:**
Director of Workforce	**May 2023**

Action Point Reference 7 – Whistleblowing	
Finding:	
The SGC Annual Statement of Assurance gives a detailed summary over whistleblowing arrangements since implementation started in April 2021 but did not provide an overt opinion on the adequacy of current whistleblowing arrangements within NHS Fife.	
Audit Recommendation:	
To enable the SGC to provide an overt opinion on the adequacy of NHS Fife's whistleblowing process as part of its Annual Statement of Assurance, the arrangements for providing the annual whistleblowing report should be reviewed to enable the required information to be provided as part of the year end process. A concluding statement from the Whistleblowing Champion should also form part of the year end assurance process.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
Although the govenance timescales do not allow for the Whistleblowing Annual Report to be aligned with the year end assurance reporting, the Annual Assurance Statement will be reviewed in collaboration with the Non-Executive Whisteblowing Champion to ensure appropriate information is incorporated into year end process to support the SGC assessment of the whistleblowing process.	
Action by:	**Date of expected completion:**
Director of Workforce	**May 2023**

FINANCIAL GOVERNANCE

Corporate Risk:

13 Delivery of a balanced in-year financial position

Score 16 High; Target 12 Moderate

There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.

14 Delivery of recurring financial balance over the medium-term

Score 16 High; Target 12 Moderate

There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.

Financial Environment

The ADP for 2022/23 was approved by NHS Fife Board on 27 September 2022. SG Quarter 1 feedback was that '*all boards are facing a challenging financial position and we note that, at the time the plans were developed, there was considerable uncertainty around expected allocations. We would therefore ask that ADPs are regularly reviewed to ensure they are deliverable within the current financial envelope and from within expected staffing levels'.*

The Director of Finance and Strategy provided a mid-year report on the Financial Position to the EDG on 22 October 2022, and then the FPRC in November 2022. In summary, the forecast outturn for Health retained services at the end of March 2023, in the absence of any actions to mitigate costs, was an overspend of £21.9m. This includes the planned financial deficit of £10.4m and further cost pressures of £11.5m.

The report references a Scottish Government (SG) letter of 12 September 2022 which reemphasised '*the requirement to deliver the £10.4m position, including the cost impact of Covid, as a minimum'.*

Papers presented to the Board have highlighted many risks to the achievement of the target deficit budget position of £10.4m and its achievement is highly unlikely.

Financial Planning

The Strategic Financial Plan 2022/23 was approved by the NHS Fife Board on 28 March 2022. This identified a projected budget gap for 2022/23 of £24.1m with plans for this to be mitigated in part through a range of cost improvement plans and a significant capital to revenue transfer. The forecast financial position after the application of these proposed actions was a deficit of £10.4m.

The 3 year financial plan was approved by NHS Fife Board at its meeting on 27 September 2022. This plan has been updated since March to reflect revised planning assumptions issued by SG and extended to cover the three-year period as advised by SG. This plan includes the changes around additional Covid funding.

The financial gap highlighted in the original financial plan to the NHS Fife Board in March 2022 remains the same at £10.4m. However the following assumptions have been made which will be very challenging:

- *The approved cost improvement programme of £11.7m will be delivered during 2022-23*
- *The board will maintain the financial gap confirmed in March 2022 and will pursue potential new opportunities to reduce the gap, in conjunction with ongoing discussion with SG.*

Other assumptions within the financial plan have now changed due to SG decisions. IJB Earmarked reserves , originally intended to offset additional health delegated and set aside costs due to Covid, are not now available and the costs will have to be covered by the NHS Fife core allocation. These are fundamental changes to original financial planning assumptions, which are being managed and reported within the IPQR, and are making the achievement of financial targets extremely challenging.

Financial Reporting

Finance reporting to Board and FPRC has been transparent and open and the Director of Finance and Strategy has consistently and clearly articulated financial challenges through EDG, Standing Committees and the Board. However, there would be benefit, given the importance of these issues, in ensuring that all members are able to understand the technical language used in finance reports and that this does not obscure key messages.

Finance Risk Reporting

The Financial Sustainability BAF, last reported as a High risk to the FPRC in September 2022, recognised the ongoing impact of Covid funding implications and the reduced availability of Covid funding due to inflationary pressure and service demand. High levels of unscheduled care along with workforce fatigue impacting on cost improvement programmes were also highlighted as current challenges. The Financial Improvement/Sustainability (FIS) Programme was highlighted as a key enabling programme to support the delivery of NHS Fife's new and medium term financial sustainability.

There are two corporate financial risks, one for in year delivery of the financial plan and the second related to the longer term financial plan. These risks were first reported to the FPRC at the 15 November 2022 meeting. We welcome this approach for managing finance related risks with a clear split between short and long term financial planning/reporting which should allow for greater clarity around the reporting on adequacy and effectiveness of key controls and key actions. We also welcome the 'deep dive' report provided 'on the aim of achievement of in year financial balance'.

The risk reporting process will continue to evolve over the coming months and we would recommend detailed consideration of both target and actual risks, which need to reflect the extreme pressures the Board is facing, which have been well reported. In particular, the target risk scores due to be achieved by 31 March 2023 appear to be optimistic in the circumstances.

The 3-year financial plan also highlights a number of risks which continue to have an impact on the delivery of the financial plan, which are not all clearly incorporated within either of the two corporate finance risks. The Financial Plan identifies that '*significant but as yet unknown employment issues with financial implications have not been included in the medium term financial plan'*. Workforce risks, together with finance and unrealistic expectations are fundamental risks facing the NHS and will need to be managed and reflected within overall strategy, workforce plans, the updates to Financial Plans and the Corporate Risks.

Cost Improvement Plans (Savings)

Over the last year NHS Fife has progressed work through its Strategic Planning and Resource Allocation (SPRA) process with the aim of helping to deliver financial balance. NHS Fife has established a Financial Improvement and Sustainability (FIS) Programme with the aim to deliver financial improvement and sustainability, with a FIS Programme Board in place. Membership of the FIS Programme Board is appropriate, with the FIS Board having a clear remit and objectives, governance processes and a benefits delivery tracker.

In addition to having oversight of delivery of approved cost improvement plans, the FIS Programme Board also consider a "pipeline" of future plans and developments.

A Cost Improvement Plans (CIP) progress report was presented to the November 2022 FPRC. At the

end of August £2.628m of anticipated CIP of £4.312m was achieved, resulting in a current year to date shortfall of £1.684m. Recurring savings achieved were £1.075m, equivalent to 9% of the full year target. At this stage in the financial year a significant risk remains around the delivery of the overall £11.7m CIP target but overall financial plan for 2022/23 assumes that all CIPs will be delivered by financial year end and also that there will be no impact on the quality of patient care and safety.

Savings identified within the FIS Programme are mainly operational rather than strategic in nature and there are, as yet, no clear links to the process for developing overall strategy. To achieve financial stability in the medium to long term, the PHWS will need to identify priority areas and disinvestment opportunities, with clear linkages to savings and transformation programmes.

Standards of Business Conduct

The Board Secretary is currently updating the Standards of Business Conduct to ensure they reflect best practice and guidance. In addition, a guidance document on how the Standards of Business Conduct applies to staff has been appended which will enhance and strengthen the process.

Capital

An interim update PAMS was endorsed by the FPRC and approved by the NHS Fife Board in September 2022. The PAMS is required to be submitted to the SG every two years with an interim report PAMS in between. The PAMS is clear on its role as an enabling strategy as part of the Population Health and Wellbeing Strategy development.

Through the Estates, Facilities and Capital Planning SPRA process, strategic priorities have been identified for now and the future. These priorities are included in the PAMS as an action plan against which progress will be reported to the Fife Capital Investment Group and the FPRC.

We note the PAMS highlights 'the current situation and strategic and political context are enabling consideration of positive and bold changes regarding the Mental Health inpatient estate'. We commend this approach around developing mental health facilities across NHS Fife.

An external review of Primary Care Premises is at draft report stage and, as outlined in the PAMS, includes short, medium and long-term service and premises recommendations. The report will be considered by NHS Fife, Fife Health & Social Care Partnership and key stakeholders and a plan to progress actions will be developed by March 2023.

A new Corporate Risk for Prioritisation & Management of Capital Funding has been developed to support the Population Health & Wellbeing Strategy. The PAMS includes risks under the themes of capital projects; strategy; Sustainability Policy; and Estates and Facilities, with each of these to be included within the Corporate Risk.

The Capital Plan 2022/23 was endorsed at the March 2023 FPRC and approved at the NHS Fife Board meeting. There are clear links from the Capital Plan to the PAMS.

The FPRC receive regular updates on current major capital projects. It has been reported in the recent IPQR, that the capital programme is expected to be delivered in full and will include the completion of the National Treatment Centre – Fife Orthopaedics.

Asset Verification

Physical checking of a sample of assets is a management requirement within the NHS Fife Financial Operating Procedures. Internal Audit have been informed that due to covid physical checking of equipment has not been undertaken however plans are in place to have this done before financial year end.

Action Point Reference 8 – Finance Risks – Corporate Risk Register	
Finding:	
We have been informed that the current Financial Sustainability BAF will be split into two new corporate risks. One will focus on in year delivery of the current financial plan and the second will consider the wider delivery of the 3 year financial plan. This approach should provide a more detailed and focussed management of financial risks as part of the updating of the NHS Fife Risk Framework. The 3 year Financial Plan did list a number of constituent risks and assumptions to financial balance, not all of which were reflected in the previous BAF.	
Audit Recommendation:	
The risks and assumptions included in the 3 year Financial Plans should be incorporated within the new, split corporate financial risks.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The risks and assumptions are very detailed and the Director of Finance and Strategy recently performed Deep Dive with the FPRC on each risk taking them through the position. **No further action required.**	
Action by:	**Date of expected completion:**
N/A	**N/A**

INFORMATION GOVERNANCE

Information Governance

Corporate Risks:

Risk 17 – Cyber Resilience – High Risk (16); Target (12) Moderate

There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.

Risk 18 – Digital and Information – High Risk (15);Target (10) Moderate

There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care.

Previous ICE and Annual Internal Audit Report Recommendations

Action had been completed to address all Information Governance (IG) related recommendations from our previous ICE and Annual Reports. We commend the work undertaken to improve assurance and governance arrangements for this important area. The establishment of regular reporting to the CGC on Information Governance & Security and on the delivery of the Digital and Information Strategy, in addition to the minutes of the relevant groups being presented, allows CGC members to more effectively scrutinise the assurance provided.

Work is underway to further improve the quality of the assurance provided on IG and Security, including obtaining better data (eg on IG Training) and developing a combined report following a mapping exercise to identify commonality between the various legislative and directive requirements primarily focussed on the Information Commissioner's Office Accountability Framework (ICOAF) and the Network & Information System Regulations (NISR). A draft approach to this revised reporting will be discussed at the IG & Security Group in January 2023. Given the significant workload involved in the mapping and developing reporting on the 338 ICO Accountability Framework controls and 434 NISR controls, there may well be benefit in approaching the SG to consider a rationalised and streamlined approach across NHS Scotland, learning from the approach taken by NHS Fife.

Governance

The Information Governance and Security Steering Group (IG&SSG) and Digital and Information Board (D&IB) continue to provide assurance to the CGC with the latest IG&S update presented to CGC in September 2022 and an update on the D&I Strategy provided in July 2022 with further updates on both scheduled on the CGC workplan for March and January 2023 respectively.

Risk Management

The format of risk reporting to IG&SSG continues to evolve and the overall NHS Fife approach to Risk Management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework BAFs. Reporting to IG&SSG is well structured and promotes discussion on whether current and planned mitigations will be sufficient to reduce the risk score to its target level before the risk materialises, including helpful consideration of risk velocity, a key consideration for IG risks.

The latest risk report presented to IG&SSG included graphical representation of the 29 risks recorded with 8 scored as high, 18 scored as medium and 3 scored as low. This showed that 8 risks had improved scores and 1 risk had deteriorated. Further analysis is provided of high level risks

including details on root cause and mitigating actions and status against target implementation timescales for these.

The latest risk report presented to D&IB included graphical representation of the 42 risks recorded with 12 scored as high, 20 scored as medium and 10 scored as low. This showed that 17 risks had improved scores and no risks had deteriorated. Further analysis is provided of high level risks including details on root cause and mitigating actions and status against target implementation timescales for these.

The two Information Governance corporate risks have been aligned to the CGC for scrutiny. We did note that in the initial presentation of these risks to CGC at their 4 November 2022 meeting that the mitigations to the D&I Strategy risk (risk 18) do not include the D&I Workforce Plan which we would see as a key control.

We will consider the papers presented to CGC during the remainder of 2022/23 to determine whether the new deep dive reports and enhanced scrutiny at CGC meetings allows the CGC to provide reasonable assurance on these risks at year-end, including accuracy of scores, adequacy and effectiveness of key controls and key actions. We will also consider how the risk management reporting at CGC interacts with the reporting to IG&SSG and D&IB.

Digital and Information Strategy

The update presented to CGC on 1 July 2022 highlighted those elements of the D&I Strategy which will not be delivered by 31 March 2024 and acknowledged that '*The financial impact alone identifies the requirement for re-prioritisation to take place over the remaining term of the strategy and through the organisation's SPRA process*' and '*The primary focus will be to agree a prioritised workplan for the remaining 2 year of the strategy, that matches the resource and finance availability and to raise general visibility and identify support necessary for digital projects at an SLT level*'. A revised delivery plan was presented to the Digital and Information Board in October 2022 with an update to the NHS Fife Clinical Governance Committee scheduled for January 2023. It is vital that this update identifies the impact of any areas which will not be delivered on the Strategic Objectives of the Health Board and IJB.

The regular portfolio and project updates provided to the D&IB outline the status of projects and their strategic alignment.

Information Governance Responsibilities

An NHS Fife Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place and the SIRO is an Executive member of the Board.

Information Governance Policies and Procedures

The status of IG related policies is now reported to IG&SSG with the most recent report presented in October 2022 indicating that all 5 policies were within their review date. The two key policies that had lapsed review dates have been updated, approved and published on Stafflink:

- GP/I5 - Information Security Policy NHS Fife – review date January 2025
- GP/D3 – NHS Fife Information Governance and Data Protection Core Policy review date August 2023

Superseded GP/D3 policy - NHS Fife Data Protection & Confidentiality Policy was still published on Stafflink.

Information Governance Incidents and Reporting

The latest IG&S update report presented to CGC on 2 September 2022 includes an appended table that shows the overall number of IG related incidents, the number of these reported to the ICO and the number of these reported within the 72 hour statutory timescale and the number that required

an ICO follow-up. This reporting could be improved by adding a short narrative section in the report including information on compliance with the 72-hour statutory timescale for reporting to the ICO and an opinion regarding whether any of the incidents reported to date will require to be included as disclosures in the Board's Governance statement.

Action Point Reference 9 – IG&S Assurance Reporting	
Finding:	
Work is underway to further improve the quality of the assurance provided on IG and Security including developing a combined report following a mapping exercise identifying commonality between the various legislative and directive requirements primarily focussed on the Information Commissioner's Office Accountability Framework (ICOAF) and the Network & Information System Regulations (NISR). A draft approach to this revised reporting is to be discussed at the Information Governance & Security Group in January 2023.	
Audit Recommendation:	
Given the significant workload involved in the mapping and developing reporting on the 338 ICO Accountability Framework controls and 434 NISR controls, there may well be benefit in approaching the SG to consider a rationalised and streamlined approach across NHS Scotland, learning from the approach taken by NHS Fife.	
Assessment of Risk:	
Merits attention	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The assurance framework will be provided to Scottish Government as demonstration of the controls and duplications of evidence requested via the ICO Accountability Framework and NIS Regulations. NHS Fife will have limited impact on the actions taken from the sharing, other than to re-enforce the findings via the National Information Governance Review Programme	
Action by:	**Date of expected completion:**
Associate Director of Digital and Information	**31 March 2023**

Action Point Reference 10 – IG Incident Reporting to CGC	
Finding:	
The latest IG&S update report presented to CGC on 2 September 2022 does not include any narrative on IG Incident Management.	
Audit Recommendation:	
A section on IG Incident Management should be added to the narrative section in the report including: • Reasons for any instances of non-compliance with the 72 hour statutory timescale for reporting to the ICO and what has been done to prevent this from happening in future • Sufficient information to allow an opinion on whether any of the incidents reported to date should be considered for disclosure within the Board's Governance statement.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The current incident management incidents are reported in a confidential monthly SIRO Report. **A section on the Information Governance and Security Incident Management approach will be provided to record, the number of reportable incidents, the current status of the incidents (until closed) and the themes or learning from these incidents.** **This will be evidenced in the next IG&S Assurance report that will be presented to Clinical Governance Committee on 3rd March 2023, with approved minutes evidencing the inclusion available following the May 2023 meeting**	
Action by:	**Date of expected completion:**
Associate Director of Digital and Information	**31 May 2023**

Action Point Reference 11 – D&I Strategy Risk	
Finding:	
The report to November 2022 CGC on the D&I Strategy risk (risk 18) did not include the D&I Workforce Plan as a key control over a fundamental risk component.	
Audit Recommendation:	
The D&I Workforce Plan should be added to the Corporate Risk Register as a mitigation to risk 18 – regarding the D&I Strategy to allow assessment of its implementation and effectiveness.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The current Workforce Plan is being updated to reflect necessary changes identified through the SPRA Process for 2023/24 and Workforce consideration identified through the Digital and Information's iMatter and Managers Networking Forum. **The revised workforce plan will be further aligned to the Corporate Risk 18 – Digital and Information Strategy risk through this work.**	
Action by:	**Date of expected completion:**
Associate Director of Digital and Information	**30 May 2023**

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	1 (Ref 3)
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	10 (Ref 1, 2, 4, 5, 6, 7, 8, 9, 10 & 11)

NHS Fife

External Audit Annual Plan 2022/23

March 2023

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Introduction

Azets have been appointed by Audit Scotland as the external auditor to NHS Fife ("the Board") for the period 2022/23 to 2026/27.

This document summarises the work plan for our 2022/23 external audit. The core elements of our work include:

- an audit of the 2022/23 annual report and accounts.
- consideration of the wider scope areas of public audit work.
- any other work requested by Audit Scotland.

We expect that our audit will have a similar underlying approach to that of your previous external auditor, Audit Scotland, although there are some changes to the Code of Audit Practice and auditing standards that come into effect for the first time in 2022/23, which are reflected in this document.

Adding value

All of our clients quite rightly demand of us a positive contribution to meeting their ever-changing business needs. We will add value by being constructive and forward looking, by identifying areas of improvement and by recommending and encouraging good practice. In this way we aim to promote improved standards of governance, better management and decision making and more effective use of public money.

Any comments you may have on the service we provide would be greatly appreciated. Comments can be reported directly to any member of your audit team.

Openness and transparency

This report will be published on Audit Scotland's website www.audit-scotland.gov.uk.

Audit scope and general approach

Responsibilities of the auditor and the Board

The Code of Audit Practice outlines the responsibilities of external auditors appointed by the Auditor General for Scotland and it is a condition of our appointment that we follow it.

Auditor responsibilities are derived from statute, International Standards on Auditing (UK) and the Ethical Standard for auditors, other professional requirements and best practice, the Code of Audit Practice and guidance from Audit Scotland.

The Board has primary responsibility for ensuring the proper financial stewardship of public funds. This includes preparing a set of annual report and accounts that are in accordance with proper accounting practices. The Board is also responsible for complying with legislation and putting arrangements in place for governance and propriety that enable it to successfully deliver its objectives.

Appendix 1 provides further details of both our responsibilities and those of the Board.

Risk-based audit approach

We follow a risk-based approach to the audit that reflects our overall assessment of the relevant risks that apply to the Board. This ensures that our audit focuses on the areas of highest risk. Our audit planning is based on:

Discussions with senior officers	**Our understanding of the health sector, its key priorities and risks**	**Attending & observing the Audit & Risk Committee**
Guidance from Audit Scotland	**Discussions with Audit Scotland and public sector auditors**	**Discussions with internal audit and review of plans and reports**
Review of the Board's corporate strategies and plans	**Review of the Board's corporate risk register**	**Consideration of the work of other inspection bodies**

Planning is a continuous process and our audit plans are updated during the course of our audit to take account of developments as they arise.

Communication with those charged with governance

Auditing standards require us to make certain communications throughout the audit to those charged with governance. These communications will be through the Audit and Risk Committee.

Professional standards and guidance

We perform our audit of the financial statements in accordance with International Standards on Auditing UK (ISAs (UK)), Ethical Standards, and applicable Practice Notes and other guidance issued by the Financial Reporting Council (FRC).

Partnership working

We coordinate our work with Audit Scotland, internal audit, other external auditors and relevant scrutiny bodies, recognising the increasing integration of service delivery and partnership working within the public sector.

Our new Audit Scotland appointments include Fife Integration Joint Board and Fife Council. Where practicable and appropriate we will share knowledge between our teams to generate efficiencies in the delivery of our audits.

Audit Scotland

Although we are independent of Audit Scotland and are responsible for forming our own views and opinions, we do work closely with Audit Scotland throughout the audit. This helps identify common priorities and risks, treat issues consistently across

the sector, and improve audit quality and efficiency. We share information about identified risks, good practices and barriers to improvement so that lessons to be learnt and knowledge of what works can be disseminated to all relevant bodies.

Audit Scotland undertakes national performance audits on issues affecting the public sector. We may review the Board's arrangements for taking action on any issues reported in the national performance reports which have a local impact. We also consider the extent to which the Board uses the national performance reports as a means to help improve performance at the local level.

During the year we may also be required to provide information to Audit Scotland to support the national performance audits.

Sharing intelligence for health and social care

The Sharing Intelligence for Health and Social Care Group enables seven national agencies[1] to share and consider intelligence about the quality of health and social care systems across Scotland. The aim of the group is to support improvement in the quality of health and social care. When any of the agencies has a potentially serious concern about a health and social care system, the group ensures this is shared and acted upon appropriately.

We are required to complete an intelligence return and attend the group meeting when the Board is being considered. Attendance at the meeting also provides us with the opportunity to hear intelligence from other agencies.

Internal Audit

As part of our audit, we consider the scope and nature of internal audit work and look to minimise duplication of effort, to ensure the total audit resource to the Board is used as efficiently and effectively as possible.

Shared systems and functions

Audit Scotland encourages auditors to seek efficiencies and avoid duplication of effort by liaising closely with other external auditors, agreeing an appropriate division of work and sharing audit findings. Assurance reports are prepared by service auditors in the health sector covering the national systems / arrangements. We consider the audit assurance reports when evaluating the Board's systems.

[1] The seven national agencies referred to are: Healthcare Improvement Scotland, NHS Education for Scotland, the Care Inspectorate, Audit Scotland, the Scottish Public Services Ombudsman, the Mental Welfare Commission for Scotland and Public Health Scotland.

Delivering the audit – post pandemic

Hybrid audit approach

We intend to adopt a hybrid approach to our audit which combines on-site visits with remote working; learning from the better practices developed during the pandemic.

All of our people have the equipment, technology and systems to allow them to work remotely or on-site, including secure access to all necessary data and information.

All of our staff are fully contactable by email, phone call and video-conferencing.

Meetings can be held over Skype, Microsoft Teams or by telephone.

We employ greater use of technology to examine evidence, but only where we have assessed both the sufficiency and appropriateness of the audit evidence produced.

Secure sharing of information

We use a cloud-based file sharing service that enables users to easily and securely exchange documents and provides a single repository for audit evidence.

Regular contact

During the 'fieldwork' phases of our audit, we will arrange regular catch-ups with key personnel to discuss the progress of the audit. The frequency of these meetings will be discussed and agreed with management.

Signing annual accounts

Audit Scotland recommends the electronic signing of annual accounts and uses a system called DocuSign.

Electronic signatures simplify the process of signing the accounts and are acceptable for laying in Parliament. Accounts can be signed using any device from any location. There is no longer a need for duplicate copies to be signed, thus reducing the risk of missing a signature and all signatories have immediate access to a high-quality PDF version of the accounts.

Approach to audit of the annual accounts

Our objective when performing an audit of the annual accounts is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement and to issue an auditor's report that includes our auditor's opinion.

As part of our general approach, we will:

- perform risk assessment procedures including updating our understanding of the entity and its environment, the financial reporting framework and system of internal control;
- review the design and implementation of key internal controls;

- identify and assess the risks of material misstatement, whether due to fraud or error, at the financial statement level and the assertion level for classes of transaction, account balances or disclosures;
- design and perform audit procedures responsive to those risks, to obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion; and
- exercise professional judgment and maintain professional scepticism throughout the audit recognising that circumstances may exist that cause the financial statements to be materially misstated.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. We include an explanation in the auditor's report of the extent to which the audit was capable of detecting irregularities, including fraud, and respective responsibilities for prevention and detection of fraud.

Key audit developments in 2022/23

Revised auditing standards[2], which come into effect from the current year, will have a significant impact on the way we perform our audit, particularly how we assess the risk of material misstatement, our approach to the audit of fraud, and the ways we ensure our audits are performed in line with regulatory requirements and to a high standard. The in-depth nature of these additional procedures, as well as updated tools and techniques that may come into scope, will also offer additional opportunity to provide insights and constructive feedback on the way the Board manages risks. Appendix 2 provides further details on the implications of these new requirements.

Materiality

We apply the concept of materiality both in planning and performing the audit, and in evaluating the effect of identified misstatements on the audit and of uncorrected misstatements. In general, misstatements, including omissions, are considered to be material if, individually or in the aggregate, they could reasonably be expected to

[2] Revisions to ISA (UK) 315 on auditors' responsibility to identify and assess the risks of material misstatement in the financial statements and ISA (UK) 240 on material misstatements caused by fraud came into effect for audits of financial statements with periods commencing on or after 15 December 2021.

influence the economic decisions of users taken on the basis of the financial statements.

Judgments about materiality are made in the light of surrounding circumstances and are affected by our perception of the financial information needs of users of the financial statements, and by the size or nature of a misstatement, or a combination of both.

The basis for our assessment of materiality is set out in Appendix 3.

Accounting systems and internal controls

The purpose of an audit is to express an opinion on the financial statements. As part of our work, we consider certain internal controls relevant to the preparation of the financial statements such that we are able to design appropriate audit procedures. However, this work is not for the purpose of expressing an opinion on the effectiveness of the controls.

We will report to the Board significant deficiencies in internal controls that we identify during the audit. The scope of our work is not designed to be an extensive review of all internal controls.

Specialised skill or knowledge required to complete the audit procedures

Our intended audit approach is to consult internally with our Technology Risk team for them to support the audit team in assessing the information technology general controls (ITGC).

Going concern

In most public sector entities (including health boards), the financial reporting framework envisages that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist.

For many public sector entities, the financial sustainability of the entity is more likely to be of significant public interest that the application of the going concern basis. Our wider scope audit work considers the financial sustainability of the Board.

Group audit scope and risk assessment

As Group auditor, we are required to obtain sufficient appropriate audit evidence regarding the financial information of the components and the consolidation process to express our opinions on the group financial statements.

The Group consists of the following entities:

Component	Significant	Level of response required
NHS Fife	Yes	Comprehensive
Fife Integration Joint Board (IJB)	No	Analytical
Fife Health Board Endowment Fund (Fife Health Charity)	No	Analytical

Comprehensive – the component is of such significance to the group as a whole that an audit of the component's financial statements is required for group reporting purposes.

Analytical - the component is not significant to the Group and audit risks can be addressed sufficiently by applying analytical procedures at the Group level.

Risks at the component-level

At this stage of our audit cycle we have only identified significant risks in NHS Fife. These are detailed in the Significant and other risks of material misstatement section of our plan. We have not identified any risks in the other components.

Prevention and detection of fraud or error

In order to discharge our responsibilities regarding fraud and irregularity we require any fraud or irregularity issues to be reported to us as they arise. In particular we require to be notified of all frauds which:

- Involve the misappropriation of theft of assets or cash which are facilitated by weaknesses in internal control and;
- Are over £5,000.

We also require a historic record of instances of fraud or irregularity to be maintained and a summary to be made available to us after each year end.

National Fraud Initiative

The National Fraud Initiative (NFI) in Scotland is a biennial counter fraud exercise led by Audit Scotland working together with a range of Scottish public bodies, external auditors and overseen by the Cabinet Office for the UK as a whole. The most recent NFI exercise commenced in 2022, with matches received for investigation from January 2023. As part of our 2022/23 audit, we will monitor the Board's participation and progress in the NFI.

Anti-money laundering

We require the Board to notify us on a timely basis of any suspected instances of money laundering so that we can inform Audit Scotland who will determine the necessary course of action.

Wider audit scope work

The special accountabilities that attach to the conduct of public business, and the use of public money, mean that public sector audits must be planned and undertaken from a wider perspective than in the private sector. This means providing assurance, not only on the financial statements, but providing audit judgements and conclusions on the appropriateness, effectiveness and impact of corporate governance and performance management arrangements and financial sustainability. Appendix 1 provides detail of the wider scope areas of public sector audit work. Our initial risk assessment and scope of work planned for 2022/23 is outlined in the 'Wider Scope' section of this plan.

National risk assessment

Where particular areas of national or sectoral risk have been identified by the Auditor General, they will request auditors to consider and report on those risks as they apply at a local level. For 2022/23 the following areas have been identified:

- Climate Change
- Cyber Security.

Appendix 4 provides further detail as to the scope of this work.

Best Value

Ministerial guidance to Accountable Officers for public bodies sets out their duty to ensure that arrangements are in place to secure Best Value in public services. Through our wider scope audit work, we will consider the arrangements put in place by the Accountable Officer to meet these Best Value obligations.

Reporting our findings

We will provide judgements on the pace and depth of improvement in reporting our findings on the wider scope areas. We will use the following gradings to provide an overall assessment of the arrangements in place.


There is a fundamental absence or failure of arrangements in place
There is no evidence to support improvement
Substantial unmitigated risks affect achievement of corporate objectives
Arrangements are inadequate or ineffective
Pace and depth of improvement is slow
Significant unmitigated risks affect achievement of corporate objectives
No major weaknesses in arrangements but scope for improvement exists
Pace and depth of improvement are adequate
Risks exist to achievement of operational objectives
Effective and appropriate arrangements are in place
Pace and depth of improvement are effective
Risks to achievement of objectives are managed

Significant and other risks of material misstatement

Significant risks are risks that require special audit consideration and include identified risks of material misstatement that:

- our risk assessment procedures have identified as being close to the upper range of the spectrum of inherent risk due to their nature and a combination of the likelihood and potential magnitude of misstatement; or
- are required to be treated as significant risks by auditing standards, for example in relation to management override of internal controls.

Significant risks at the financial statement level

The table below summarises the significant risks of material misstatement identified at the financial statement level. These risks are considered to have a pervasive impact on the financial statements as a whole and potentially affect many assertions for classes of transaction, account balances and disclosures.

Identified risk of material misstatement	Audit approach
Management override of controls Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Although the level of risk will vary from entity to entity, this risk is nevertheless present in all entities. Due to the unpredictable way in which such override could occur, it is a risk of material misstatement due to fraud and thus a significant risk. **Risk of material misstatement: Very High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Documenting our understanding of the journals posting process and evaluating the design effectiveness of management controls over journals. • Analysing the journals listing and determining criteria for selecting high risk and / or unusual journals. • Testing high risk and / or unusual journals posted during the year and after the unaudited annual accounts stage back to supporting documentation for appropriateness, corroboration and to ensure

Identified risk of material misstatement	Audit approach
	approval has been undertaken in line with the Board's journals policy. • Gaining an understanding of the accounting estimates and critical judgements made by management. We will challenge assumptions and consider the reasonableness and indicators of bias which could result in material misstatement due to fraud. • Evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions.

Significant risks at the assertion level for classes of transaction, account balances and disclosures

Identified risk of material misstatement	Audit approach
Fraud in revenue recognition Material misstatement due to fraudulent financial reporting relating to revenue recognition is a presumed risk in ISA 240 (The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements). The presumption is that the Board could adopt accounting policies or recognise income in such a way as to lead to a material misstatement in the reported financial position. Given the financial pressures facing the public sector as a whole, there is an inherent fraud risk associated with the recording of income around the year end. In respect of Scottish Government funding, however, we do not consider the revenue recognition risk to be significant due to a lack of incentive and opportunity to manipulate revenue of this nature. The risk of fraud in relation to revenue recognition is however present in all other income streams. **Inherent risk of material misstatement:** • **Revenue (occurrence / completeness): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating the significant income streams and reviewing the controls in place over accounting for revenue. • Considering the Board's key areas of income and obtaining evidence that income is recorded in line with appropriate accounting policies and the policies have been applied consistently across the year.

Identified risk of material misstatement	Audit approach
Fraud in non-pay expenditure As most public sector bodies are net expenditure bodies, the risk of fraud is more likely to occur in expenditure. There is a risk that expenditure may be misstated resulting in a material misstatement in the financial statements. Given the financial pressures facing the public sector as a whole, there is an inherent fraud risk associated with the recording of expenditure around the year end. **Inherent risk of material misstatement:** • **Non-pay expenditure (occurrence / completeness): High** • **Accruals (existence / completeness): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating the significant non-pay expenditure streams and reviewing the controls in place over accounting for expenditure. • Considering the Board's key areas of expenditure and obtaining evidence that expenditure is recorded in line with appropriate accounting policies and the policies have been applied consistently across the year. • Reviewing accruals around the year end to consider if there is any indication of understatement of balances held through consideration of accounting estimates.

Identified risk of material misstatement	Audit approach
Commitments under PFI contracts The Board has two PFI contracts: 1. Community Hospital and Health Centre in St Andrews. The contract is for a period of 30 years commencing 31 July 2009. 2. Phase 3 of the Victoria Hospital site in Kirkcaldy. The contract is for a period of 30 years commencing 28 October 2011. These initiatives are recognised as non-current assets on the Board's balance sheet with the net book value as at 31 March 2022 of £29million and £182million respectively. The liability to pay for these assets is in substance of finance lease obligation. The Board pays a fixed monthly unitary payment to ensure the buildings are maintained to an agreed level of service specification. This unitary payment is subject to annual inflation. Due to the complexity of accounting and the high value of the transactions, there is a risk that the Board's financial statements do not show the correct accounting entries and related commitments, and that the unitary payments in relation to these facilities are not correctly accounted for. **Inherent risk of material misstatement:** **PPP asset (valuation): High** **Lease liabilities (valuation): High** **Expenditure (valuation): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Documenting our understanding of the Board's PFI contracts and how these are accounted for. • Reviewing evidence to support the value of these contracts. • Reviewing the Board's calculation of unitary payments. • Reviewing the Board's compliance with the FReM and NHS Manual for Accounts regarding PFI contracts.

Identified risk of material misstatement	Audit approach
Valuation of land and buildings (key accounting estimate) NHS Fife held land and buildings with a net book value of £464million at 31 March 2022, with external valuations on a five-year rolling basis. There is a significant degree of subjectivity in the measurement and valuation of land and buildings. This subjectivity and the material nature of the Board's asset base represents an increased risk of misstatement in the financial statements. **Inherent risk of material misstatement:** **Land & Buildings (valuation): Very High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating management processes and assumptions for the calculation of the estimates, the instructions issued to the valuation experts and the scope of their work. • Evaluating the competence, capabilities and objectivity of the valuation expert. • Considering the basis on which the valuation is carried out and challenging the key assumptions applied. • Testing the information used by the valuer to ensure it is complete and consistent with our understanding. If there have been any specific changes to the assets in the year, we will ensure these have been communicated to the valuer. • Ensuring revaluations made during the year have been input correctly to the fixed asset register and the accounting treatment within the financial statements is correct. • Evaluating the assumptions made by management for any assets not revalued during the year and how management are satisfied that these are not materially different to the current value.

Identified risk of material misstatement	Audit approach
IFRS 16 Implementation (key accounting estimate) The adoption of IFRS 16 on leases was delayed for NHS organisations and was implemented from 1 April 2022 therefore impacting on the 2022/23 financial statements for the first time. There is a risk that lease terms, lease payments and the discount rate used to measure lease liabilities are inappropriately determined, therefore creating a risk that the financial statements are materially misstated. There is also a potential risk that lease liabilities are not completely recorded. **Inherent risk of material misstatement:** **Right of Use Asset (valuation): High** **Right of Use Asset (completeness): High** **Lease liabilities (valuation): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating the Board's process for reviewing lease arrangements and contracts to determine leases falling within the remit of IFRS 16. • Testing the completeness and accuracy of the data collected by the Board and used as part of the implementation of IFRS 16. • Assessing the key judgements and decisions made about material contracts such as property leases or where lease terms are not prescriptive. • Reviewing the appropriateness of the discount rate used in the calculation of the lease liability. • Reperforming the calculation of the lease liability and right of use asset for a sample of leases. • Reviewing the accounting policy and related disclosures for IFRS 16 in line with the requirements of the Financial Reporting Manual (FReM), NHS Manual for Accounts and Scottish Government guidance.

Identified risk of material misstatement	Audit approach
Provisions- CNORIS (key accounting estimate) The Board's financial statements includes provision for legal obligations in respect of clinical and medical obligations and participation in CNORIS (Clinical Negligence and Other Risks Indemnity Scheme). There is a significant degree of subjectivity in the measurement and valuation of these provisions. This subjectivity represents an increased risk of misstatement in the financial statements. **Inherent risk of material misstatement:** **Provisions (valuation): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Reviewing management's estimation for the provision and related disclosures. • Considering compliance with the requirements of the FReM and NHS Manual for Accounts. • Considering the competence, capability and objectiveness of the management expert.

Other identified risks

Other identified risks are those which, although not considered to be significant, will require specific consideration during the audit.

Upgrade to eFinancials

The eFinancials system was upgraded at the start of 2023. There has been significant disruption to some elements of the system since this update. Three issues were identified to have significantly impacted on the provision of services within the health finance teams:

1. Performance of the system leading to delayed posting of very large month end journals and for some transactions these requiring to be broken down
2. Instability of DbCapture resulting in some Boards reverting to paying invoices manually
3. Difficulties in running reports resulting in a delay to reporting month 10 position.

While we understand these issues have now been resolved we will consider these in the context of our audit to determine whether any have led to a misstatement in the 2022/23 financial statements. We will consider the service auditor report and findings and engage our IT specialists to support our work in this area.

Provision of payroll services

The Board's payroll services are transferring to NSS as part of a South East payroll service including NHS Fife, NHS Forth Valley, NHS Lothian and Scottish Ambulance Service. Staff transferred into NSS in February 2023. There will be a six month stabilisation period. NSS are due to provide assurances that, for the period to 31 March 2023, the controls have not changed from those operated by NHS Fife's in-house team. We will consider these arrangements as part of our review of the Board's IT controls and will engage our IT specialists to support our work in this area.

Accounting treatment for recovery of COVID-19 reserves

In 2021/22 NHS Fife received additional COVID-19 funding of £95million of which £59million was passed to Fife Integration Joint Board (the "IJB"). As at 31 March 2022, £35.993million was held as an IJB earmarked reserve.

The Scottish Government has notified health boards and integration authorities of its intention to recover part of this funding, including £21million of the COVID-19 earmarked reserves in Fife IJB. To achieve this, NHS Fife will provide reduced funding contributions to the IJB to allow utilisation of the reserves balance.

As part of our audit work we will review the accounting treatment and disclosures in the financial statements to ensure they comply with the relevant accounting standards and any other applicable guidance issued.

Wider scope

Introduction

The Code of Audit Practice frames a significant part of our wider scope responsibilities in terms of audit areas:

- Financial sustainability
- Financial management
- Vision, leadership and governance
- Use of resources to improve outcomes.

Our planned audit work against these four areas is risk based and proportionate. Our initial assessment builds upon our understanding of the Board's key priorities and risks along with discussions with management and review of board and committee minutes and key strategy documents.

We have identified one significant risk in relation to financial sustainability as set out in the table below. At this stage, we have not identified any significant risks in relation to the other wider scope areas.

Audit planning is a continuous process and we will report all identified significant risks, as they relate to the four wider scope areas, in our annual audit report. This section summarises our audit work in respect of each wider scope area.

Wider scope significant risk

Financial sustainability

The Board submitted its draft medium term financial plan to the Scottish Government, in line with set deadlines, in February 2023. The final version of the plan is due to be considered by the Finance, Performance and Resources Committee and Board in March 2023.

The draft plan shows a cumulative financial gap, before mitigations, of £73.195million over the period 2023/24 to 2027/28. A breakeven position for 2023/24 and 2024/25 and a surplus from 2025/26 onwards is forecast; however, this is subject to the delivery in full of challenging cost improvement plans and receipt of brokerage in 2023/24 and 2024/25.

The Board faces extreme challenges in achieving savings targets, reducing surge activity and reducing reliance on bank and agency staff while addressing areas of under-performance against targets and recovering from the COVID-19 pandemic. The emerging and uncertain impact on the Board's finances and ability to deliver services in a sustainable manner remains a significant challenge and risk.

Our audit response:

During our audit we will review whether the Board has appropriate arrangements in place to manage its future financial position. Our work will include an assessment of progress made in developing financially sustainable plans which reflect the medium and longer term impact of cost pressures and that continue to support the delivery of the Board's statutory functions and strategic objectives.

Our audit approach to the wider scope audit areas

Financial sustainability

Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered.

Consideration	Our audit approach
The Board continues to face significant workforce pressures, including unfilled vacancies and reliance on supplementary staff across the organisation. The Workforce Plan for 2022 – 2025 was approved by the Board in July 2022 and includes: • working with local universities to maximise recruitment of newly qualified nurses. • a programme encouraging the ongoing recruitment of staff from overseas. As at month 8, November 2022, the Board identified the impact which high levels of staff vacancy is having on its use of supplementary staffing for both nursing and medical workforces, as a primary driver for the forecast over-spend position. The Board has recognised the impact that the continued workforce pressures is having on the achievement of its short, medium and longer term financial targets.	We will review and conclude on: • The ongoing development of financial planning and modelling to identify and address risks to financial sustainability. • The appropriateness and effectiveness of arrangements in place to address any identified funding gaps. • The implementation and delivery of workforce plans to reduce the Board's reliance on supplementary staff.

Financial management

Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

Consideration	Our audit approach
The Board met all its key financial targets in 2021/22, delivering small underspends against its Revenue Resource Limit and Capital Resource Limit. This was achieved despite the impact of COVID-19 (£36million of additional costs) through additional funding from Scottish Government. In 2021/22 the Board received additional COVID-19 funding of £95million of which £59million was passed to the IJB. The Scottish Government has notified its intention to recover part of this funding, and £21million of the £35million COVID-19 funding held in IJB reserves will be transferred back to the Scottish Government through NHS Fife. As at month 8, November 2022, the Board reported an overspend of £19.562million. The 2022/23 financial plan assumed funding of £8.758million to cover COVID-19 expenditure; however, it was confirmed that only £7.5million would be received in 2022/23. The Board is working with the Health & Social Care Partnership to determine a system wide approach to support the COVID-19 cost activity for the full year. The Board approved the 2022/23 financial plan in March 2022 which included unidentified savings of £10.4million. At month 8, the Board had achieved £6.099million of its efficiency savings against the year to date target of £7.260million, with only £2.337million of savings being recurring in nature. In addition, the Board	We will review and conclude on: • The achievement of financial targets. • Whether the Board can demonstrate the effectiveness of its budgetary control system in communicating accurate and timely performance. • Whether the Board has arrangements in place to ensure systems of internal control are operating effectively. • Whether the Board has established appropriate and effective arrangements for the prevention and detection of fraud and corruption. • The effective and efficient delivery of the NTC-Fife project.

Consideration	Our audit approach
has recognised the increased challenge which the cost of living crisis, inflationary pressures and the level of system pressures will have on the achievement of the full year savings target for 2022/23. Construction of the National Treatment Centre-Fife was completed in January 2023 and the facility will open to patients from April 2023. Overall, the capital project remained within budget (£33.200million) and was completed within one month of the original timescale.	

Vision, Leadership and Governance

Vision, Leadership and Governance is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision making, and transparent reporting of financial and performance information.

Consideration	Our audit approach
The Board made progress in the development of a new Population Health and Wellbeing Strategy during 2022/23. The strategy will outline how NHS Fife will deliver its organisational strategic priorities and has a focus on population health and wellbeing. A Population Health and Wellbeing Portfolio Board was established in 2021/22 to oversee the development and delivery of the new strategy. The first draft strategy document has been produced and was shared with the Population Health and Wellbeing Portfolio Board in December 2022. The final draft strategy is due to be approved by the Board in March 2023. Board and Committee meetings continue to be held remotely through virtual means where local media and the public can request to watch Board meetings online. Meetings are expected to follow a hybrid approach from March 2023. Throughout 2022/23, to date, the Board has been able to maintain all aspects of board governance, including its regular schedule of Board and Committee meeting, to allow for effective scrutiny, challenge and informed decision making. The Board Chair term of appointment ends in March 2023. Recruitment of this post has commenced. The Board agreed to refresh its Risk Management Framework during 2022/23 which included the formation of the Risks and Opportunities Group (ROG) that first met in	We will review and conclude on: • The clarity of plans to implement the new Population Health and Wellbeing Strategy. • Whether the Board can demonstrate that the governance arrangements in place are appropriate and operating effectively. • Whether inductions and ongoing training arrangements for new Board members support effective scrutiny and challenge. • The transparency of decision-making, financial reporting and performance data. • Reasonableness and consistency of the governance statement in relation to other information gathered during our audit.

Consideration	Our audit approach
September 2022. The role of ROG includes monitoring and reviewing the risks, considering links to the Board's risk appetite, the strategic priorities, the operational risk profile, and providing critique, recommendations and assurance to Executive Directors' Group, committees and other stakeholders. In September 2022, the Board agreed that the Board Assurance Framework would be replaced by the Corporate Risk Register. Work is ongoing to ensure that the Corporate Risk Register and risk appetite are aligned to the Board's strategic priorities.	

Use of resources to improve outcomes

Audited bodies need to make best use of their resources to meet stated outcomes and improvement objectives, through effective planning and working with strategic partners and communities. This includes demonstrating economy, efficiency, and effectiveness through the use of financial and other resources and reporting performance against outcomes.

Consideration	Our audit approach
The Board and Committees receive regular updates on performance through the Integrated Performance and Quality Reports (IPQR). These reports provide assurance on the Board's performance against National Standards and Local Key Performance Indicators (KPIs). In September 2022, a revision was made to performance reporting through the production of different extracts of the IPQR for each Standing Committee to enable more efficient scrutiny of the performance areas relevant to each committee. As at month 8, November 2022, performance was the same or improved for 11 of 37 KPIs, compared to the previous year and 20 KPIs were more than 5% behind target. The key areas of declining performance include: • Waiting Times (including 4-hour emergency access, new outpatients, psychological therapies and diagnostics). • Sickness Absence. • Child Immunisation. The COVID-19 pandemic continues to have a significant impact on the Board's activity and waiting times for services. To support service recovery, the Board is progressing the targets and aims of the 2022/23 Annual Delivery Plan, which was approved by the Scottish Government in September 2022.	We will review and conclude on: • Whether the Board can evidence the achievement of value for money in the use of resources. • Whether outcomes are improving and if there is sufficient focus on improvement and the pace of it. • The Board's service recovery from the COVID-19 pandemic.

Consideration	Our audit approach
The Board has a best value framework in place. All standing committees complete a Best Value Framework assessment alongside their Annual Statement of Assurance. The assessments demonstrate the Board's commitment to continuous improvement, set out the Best Value characteristics and list measures, expected outcomes and evidence against each characteristic.	

Your Azets audit management team

Chris Brown: Engagement Lead

chris.brown@azets.co.uk

Chris is the partner in charge of our audit of NHS Fife. Chris has over 30 years' experience in NHS auditing and leads most of our external audit appointments in the health sector. Chris is a recognised specialist in public sector governance and risk management and is also our UK Head of Public Sector Audit.

Karen Jones: Engagement Manager

karen.jones@azets.co.uk

Karen is one of the directors responsible for our Audit Scotland appointments. She has considerable experience in planning and delivering public sector audits, producing management reports and liaising with senior management and audit committees.

Karen will work alongside Chris to deliver the external audit to NHS Fife.

Audit timetable

The submission deadline for the annual accounts is normally set to be consistent with the administrative deadline set by the Scottish Government. It was moved to 30 September for 2019/20 and 2020/21, and 31 August for 2021/22, but is returning to the pre-pandemic 30 June from 2022/23.

The Auditor General is required to send the audited annual accounts to the Scottish Ministers who are then required to lay the accounts in the Scottish Parliament by 31 December.

We have set out below target months which align to the Board's schedule of Audit and Risk Committee and Board meetings. We will aim to meet these scheduled meetings however this will be monitored during the audit process and may require to be revised to reflect emerging issues.

Audit work/ output	Description	Target month/s	Audit & Risk Committee	Deadline
Audit strategy	Onboarding and initial engagement, introductory meetings and presentation of audit strategy.	November	5 December 2022	N/A
Audit plan	Planning meetings, understanding the entity, risk assessment. Audit plan setting out the scope of our audit, including key audit risks, presented to the Audit & Risk Committee.	December – March	15 March 2023	31 March 2023
Interim audit	Interim audit including review of accounting systems. We will provide a verbal update to the Audit and Risk Committee on work	December - March	18 May 2023	N/A

Audit work/ output	Description	Target month/s	Audit & Risk Committee	Deadline
	carried out during our interim audit.			
Final audit	Accounts presented for audit and final audit visit begins.	May	TBC	N/A
Independent Auditor's Report	This report will contain our opinions on the financial statements, the audited part of the remuneration and staff report, annual governance statement and performance report.	June	TBC	30 June 2023
Annual Report to the Board and the Auditor General for Scotland	At the conclusion of each year's audit we issue an annual report summarising our work and all opinions, conclusions, significant issues and recommendations. This report pulls together all of our work under the Code of Audit Practice.	June	TBC	30 June 2023

Prior to submitting our outputs, we will discuss all issues with management to confirm factual accuracy and agree a draft action plan where appropriate.

The action plans within the reports will include prioritised recommendations, responsible officers and implementation dates. We will review progress against the action plans on a regular basis.

Audit fee

For 2022/23, the new auditor appointment process provided Audit Scotland with a fair representation of the current audit market and highlighted the increasing requirements, expectations and scrutiny of the audit profession.

High quality audit work is essential to successfully deliver a fully ISA and Code of Audit Practice-compliant audit. These factors have led to above inflation increases in the cost of audit. Whilst these increases are significant, they are consistent with evidence obtained from the profession and other UK audit agencies. On setting fees, Audit Scotland has ensured that efficiencies have been fully utilised to mitigate the impact.

In the health sector, the average fee increase is 21.8%, where the average fee was previously £134,673 and has risen to £163,984.

Audit Scotland sets an “expected” audit fee that assumes the body has sound governance arrangements in place, has been operating effectively throughout the year, prepares comprehensive and accurate draft accounts and meets the agreed timetable for audit. The expected fee is reviewed by Audit Scotland each year and adjusted if necessary based on auditors’ experience, new requirements, or significant changes to the audited body.

The expected fee level notified to the Board for 2022/23 is £199,850, which is £35,720 higher than the fee agreed in the previous year and reflects the sectoral increase of 21.8%.

As auditors, we negotiate a fee with the Board that reflects our assessment of the work required to address the risks identified during the planning process. The fee may be varied above the expected fee level to reflect the circumstances and local risks within the body.

For 2022/23, we propose setting the audit fee above the expected fee level to reflect the following areas of work:

Area	Fee
Additional costs associated with the first year of our audit appointment, increased focus on IT general controls, and high levels of significant audit risks within the NHS.	£15,000
Implementation of IFRS 16 and associated accounting queries.	£2,000

Our audit fee for the current year (with prior year comparatives) is as follows:

	2022/23	2021/22
Auditor remuneration	£191,700	£141,310
Pooled costs	£15,810	£15,850
Audit support costs	£6,830	£6,970
Sectoral cap adjustment	£2,510	-
Total fee	**£216,850**	**£164,130**

We assume receipt of the draft working papers at the outset of our on-site final audit visit. If the draft accounts and papers are late, or agreed management assurances are unavailable, we reserve the right to charge a fee for additional audit work. An additional fee will also be required in relation to any other significant exercises not within our planned audit activity.

Auditor independence and objectivity

We are required to communicate on a timely basis all facts and matters that may have a bearing on our independence.

In particular, FRC's Ethical Standard stipulates that where an auditor undertakes non audit work, appropriate safeguards must be applied to reduce or eliminate any threats to independence.

Azets has not been appointed to provide any non-audit services during the year. We confirm that we comply with FRC's Ethical Standard. In our professional judgement, the audit process is independent and our objectivity has not been compromised in any way. In particular there are and have been no relationships between Azets and the Board, its Board members and senior management that may reasonably be thought to bear on our objectivity and independence.

Appendix 1: Responsibilities of the Auditor and the Board

The Auditor General and Audit Scotland

The Auditor General for Scotland is a Crown appointment and independent of the Scottish Government and Parliament. The Auditor General is responsible for appointing independent auditors to audit the accounts of the Scottish Government and most Scottish public bodies, including NHS bodies, and reporting on their financial health and performance.

Audit Scotland is an independent statutory body that co-ordinates and supports the delivery of high-quality public sector audit in Scotland. Audit Scotland oversees the appointment and performance of auditors, provides technical support, delivers performance audit and Best Value work programmes and undertakes financial audits of public bodies.

Auditor responsibilities

Code of Audit Practice

The Code of Audit Practice (the Code) describes the high-level, principles-based purpose and scope of public audit in Scotland. The 2021 Code came into effect from 2022/23.

The Code of Audit Practice outlines the responsibilities of external auditors appointed by the Auditor General and it is a condition of our appointment that we follow it.

Our responsibilities

Auditor responsibilities are derived from the Code, statute, International Standards on Auditing (UK) and the Ethical Standard for auditors, other professional requirements and best practice, and guidance from Audit Scotland.

We are responsible for the audit of the accounts and the wider-scope responsibilities explained below. We act independently in carrying out our role and in exercising professional judgement. We report to the Board and others, including Audit Scotland, on the results of our audit work.

Weaknesses or risks, including fraud and other irregularities, identified by auditors, are only those which come to our attention during our normal audit work in accordance with the Code and may not be all that exist.

Wider scope audit work

Reflecting the fact that public money is involved, public audit is planned and undertaken from a wider perspective than in the private sector.

The wider scope audit specified by the Code broadens the audit of the accounts to include additional aspects or risks in areas of financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes.

Financial management

Financial management means having sound budgetary processes. Audited bodies require to understand the financial environment and whether their internal controls are operating effectively.

Auditor considerations

Auditors consider whether the body has effective arrangements to secure sound financial management. This includes the strength of the financial management culture, accountability, and arrangements to prevent and detect fraud, error and other irregularities.

Financial sustainability

Financial sustainability means being able to meet the needs of the present without compromising the ability of future generations to meet their own needs.

Auditor considerations

Auditors consider the extent to which audited bodies show regard to financial sustainability. They look ahead to the medium term (two to five years) and longer term (over five years) to consider whether the body is planning effectively so it can continue to deliver services.

Vision, leadership and governance

Audited bodies must have a clear vision and strategy, and set priorities for improvement within this vision and strategy. They work together with partners and communities to improve outcomes and foster a culture of innovation.

Auditor considerations

Auditors consider the clarity of plans to implement the vision, strategy and priorities adopted by the leaders of the audited body. Auditors also consider the effectiveness of governance arrangements for delivery, including openness and transparency of decision-making; robustness of scrutiny and shared working arrangements; and reporting of decisions and outcomes, and financial and performance information.

Use of resources to improve outcomes

Audited bodies need to make best use of their resources to meet stated outcomes and improvement objectives, through effective planning and working with strategic partners and communities. This includes demonstrating economy, efficiency and effectiveness through the use of financial and other resources, and reporting performance against outcomes.

Auditor considerations

Auditors consider the clarity of arrangements in place to ensure that resources are deployed to improve strategic outcomes, meet the needs of service users taking account of inequalities, and deliver continuous improvement in priority services.

Audit quality

The Auditor General and the Accounts Commission require assurance on the quality of public audit in Scotland through comprehensive audit quality arrangements that apply to all audit work and providers. These arrangements recognise the importance of audit quality to the Auditor General and the Accounts Commission and provide regular reporting on audit quality and performance.

Audit Scotland maintains and delivers an Audit Quality Framework.

The most recent audit quality report can be found at https://www.audit-scotland.gov.uk/publications/quality-of-public-audit-in-scotland-annual-report-202122

Board responsibilities

The Board has primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enables it to successfully deliver its objectives. The features of proper financial stewardship include the following:

Area	Board responsibilities
Corporate governance	The Board is responsible for establishing arrangements to ensure the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Those charged with governance should be involved in monitoring these arrangements.
Financial statements and related reports	The Board has responsibility for: • preparing financial statements which give a true and fair view of its financial position and its expenditure and income, in accordance with the applicable financial reporting framework and relevant legislation; • maintaining accounting records and working papers that have been prepared to an acceptable professional standard and that support its financial statements and related reports disclosures; • ensuring the regularity of transactions, by putting in place systems of internal control to ensure that they are in accordance with the appropriate authority; and • preparing and publishing, along with the financial statements, an annual governance statement, management commentary (or equivalent) and a remuneration report in accordance with prescribed requirements. Management commentaries should be fair, balanced and understandable. Management is responsible, with the oversight of those charged with governance, for communicating relevant information to users about the entity and its financial performance, including providing adequate disclosures in accordance with the applicable financial reporting framework. The relevant information should be communicated clearly and concisely. The Board is responsible for developing and implementing effective systems of internal control as well as financial, operational and

Area	Board responsibilities
	compliance controls. These systems should support the achievement of its objectives and safeguard and secure value for money from the public funds at its disposal. The Board is also responsible for establishing effective and appropriate internal audit and risk-management functions.
Standards of conduct for prevention and detection of fraud and error	The Board is responsible for establishing arrangements to prevent and detect fraud, error and irregularities, bribery and corruption and also to ensure that its affairs are managed in accordance with proper standards of conduct by putting proper arrangements in place.
Financial position	The Board is responsible for putting in place proper arrangements to ensure the financial position is soundly based having regard to: • Such financial monitoring and reporting arrangements as may be specified; • Compliance with statutory financial requirements and achievement of financial targets; • Balances and reserves, including strategies about levels and their future use; • Plans to deal with uncertainty in the medium and long term; and • The impact of planned future policies and foreseeable developments on the financial position.
Best Value	The Scottish Public Finance Manual sets out that accountable officers appointed by the Principal Accountable Officer for the Scottish Administration have a specific responsibility to ensure that arrangements have been made to secure Best Value. Accountable Officers are required to ensure accountability and transparency through effective performance reporting for both internal and external stakeholders.

Appendix 2: Impact of revised auditing standards

Revised auditing standards, which come into effect from the current year, will have a significant impact on the way we perform our audit, particularly how we assess the risk of material misstatement, our approach to the audit of fraud, and the ways we ensure our audits are performed in line with regulatory requirements and to a high standard. The table below provides further detail on the implications of these new requirements.

Key change	Potential impact on the Board & our approach
Enhanced risk identification and assessment, promoting more focused auditor responses to identified risks	Management and those charged with governance may receive more up-front questions as we plan the audit and identify and assess risks of material misstatement. We may conduct planning and risk assessment procedures at a different time to ensure that our understanding is comprehensive, and that information is leveraged effectively and efficiently. To facilitate a more robust risk-assessment, we may request additional information to enhance our understanding of systems, processes and controls. For example, we may request: • a better understanding of the Board's structure and operations and how it integrates information technology (IT) • more information about the Board's processes for assessing risk and monitoring its system of internal control • more detailed narratives about how transactions are initiated, recorded, processed and reported • policies and procedure manuals, flowcharts and other supporting documentation to validate our understanding of the information systems relevant to the preparation of the financial statements • more information to support our inherent risk assessment. This information not only informs our risk assessment but also assists us in determining an appropriate response to risks

Key change	Potential impact on the Board & our approach
	identified, including any new significant risks which require a different response.
Understanding and acting on risks associated with IT	We will be asking tailored questions and making information requests to understand the IT environment, including: • IT applications • supporting IT infrastructure • IT processes • personnel involved in the IT processes. Combined with the controls that may be needed to address the identified and assessed risks of material misstatement, this understanding may also identify existing and new risks arising from the use of IT. Therefore, we will be asking more focused questions and requesting additional information to understand the general IT controls that address such risks. For example, we may have questions in relation to general IT controls over journal entries (e.g., segregation of duties related to preparing and posting entries) to address risks arising from the use of IT. Depending on our assessment of the complexity of systems and associated risks, we may also involve additional team members, such as IT specialists.
Enhanced procedures in connection with fraud	We will be asking targeted questions as part of an enhanced approach to fraud, including discussing with the Board: • any allegations of fraud raised by employees or related parties • the risks of material fraud, including those specific to the health sector. Combined with other information, and any inconsistencies in responses from those charged with governance and management, we determine implications for further audit procedures. Work in connection with fraud may also now include the use of audit data analytics, or the inclusion of specialists in our engagement team to ensure we obtain sufficient appropriate audit evidence to conclude whether the

Key change	Potential impact on the Board & our approach
	financial statements are materially misstated as a result of fraud. In addition to existing communication and reporting requirements relating to irregularities and fraud, there may be further matters we report in connection with management's process for identifying and responding to the risks of fraud in the entity and our assessment of the risks of material misstatement due to fraud. These enhanced requirements may assist in the prevention and detection of material fraud, though do not provide absolute assurance that all fraud is detected or alter the fact that the primary responsibility for preventing and detecting fraud rests with the Board and management.
Enhanced requirements for exercising professional scepticism	Challenge, scepticism and the application of appropriate professional judgement are key components of our audit approach. You may receive additional inquiries if information is found that contradicts what our team has already learned in the audit or in instances where records or documents seen in the course of the audit appear to have been tampered with, or to not be authentic.
Using the right resources, in the right way, at the right time	One of our new strategic quality objectives sets out that we will strive to use the right resource, in the right way, at the right time. This may mean increasing the use of specialists (for example in relation to general IT controls) or changing the shape of the audit engagement team to ensure that we are able to provide appropriate challenge and feedback in specialist areas. This will include appropriate use of technology, including data analytics.

Appendix 3: Materiality

Materiality is an expression of the relative significance of a matter in the context of the financial statements as a whole. A matter is material if its omission or misstatement would reasonably influence the decisions of an addressee of the auditor's report. The assessment of what is material is a matter of professional judgement and is affected by our assessment of the risk profile of the organisation and the needs of users. We review our assessment of materiality throughout the audit.

Whilst our audit procedures are designed to identify misstatements which are material to our audit opinion, we also report to the Board and management any uncorrected misstatements of lower value errors to the extent that our audit identifies these.

	Group £million	Board £million
Overall materiality for the financial statements	14	14
Performance materiality	10.5	10.5
Trivial threshold	0.250	0.250
Materiality	Our assessment is made with reference to the Board's gross expenditure. We consider this to be the principal consideration for the users of the annual accounts when assessing financial performance. Our assessment of materiality equates to approximately 1% of the Board's gross expenditure as disclosed in the 2021/22 audited annual report and accounts. We set materiality for both the Group and the Board at the same level given our assessment and approach to the group audit. We have concluded, at the planning stages of our audit, that the IJB and Fife Health Charity are not significant components to the overall group. In performing our audit, we apply a lower level of materiality to the audit of the Remuneration and Staff Report. Our materiality is set at £5,000.	

Performance materiality	Performance materiality is the working level of materiality used throughout the audit. We use performance materiality to determine the nature, timing and extent of audit procedures carried out. We perform audit procedures on all transactions, or groups of transactions, and balances that exceed our performance materiality. This means that we perform a greater level of testing on the areas deemed to be at significant risk of material misstatement. Performance materiality is set at a value less than overall materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of the uncorrected and undetected misstatements exceed overall materiality.
Trivial misstatements	Trivial misstatements are matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria. In accordance with Audit Scotland's planning guidance this should not exceed £250,000.

Appendix 4: National risk areas under scope of audit in 2022/23

Climate change

Tackling climate change is one of the greatest global challenges. The Scottish Parliament has set a legally binding target of becoming net zero by 2045, and has interim targets including a 75% reduction in greenhouse gas emissions by 2030. The public sector in Scotland has a key role to play in ensuring these targets are met and in adapting to the impacts of climate change.

There are specific legal responsibilities placed on public bodies to contribute to reducing greenhouse gas emissions, to adapt to climate change, to act sustainably and to report on progress. A number of public bodies have declared a climate emergency and set their own net zero targets, some of which are earlier than Scotland's national targets. All public bodies will need to reduce their direct and indirect emissions, and should have plans to do so. Many bodies will also have a role in reducing emissions in wider society, and in supporting activity to adapt to the current and potential future impact of climate change. For example, working with the private sector and communities to help drive forward the required changes in almost all aspects of public and private life, from transport and housing to business support.

Public audit has an important and clear role to play in:

- helping drive change and improvement in this uncertain and evolving area of work
- supporting public accountability and scrutinising performance
- helping identify and share good practice.

The Auditor General and Accounts Commission are developing a programme of work on climate change. This involves a blend of climate change-specific outputs that focus on key issues and challenges as well as moving towards integrating climate change considerations into all aspects of audit work.

For 2022/23 audits, auditors are required to provide answers to the questions set out in the following table which are intended to gather basic information on the arrangements for responding to climate change in each body:

Key questions
What targets has the body set for reducing emissions in its own organisation or in its local area?
Does the body have a climate change strategy or action plan which sets out how the body intends to achieve its targets?
How does the body monitor and report progress towards meeting its emission targets internally and publicly?
Has the body considered the impact of climate change on its financial statements?
What are the areas of the financial statements where climate change has, or is expected to have, a material impact?
Does the body include climate change in its narrative reporting which accompanies the financial statements and is it consistent with those financial statements?

Cyber security

There continues to be a significant risk of cyber-attacks to public bodies, and it is important that they have appropriate cyber security arrangements in place.

A number of recent incidents have demonstrated the significant impact that a cyber-attack can have on both the finances and operation of an organisation.

For 2022/23 audits, auditors are advised to consider risks related to cyber security at audited bodies. However, the revised ISA (UK) 315 includes enhanced requirements for auditors to understand a body's use of IT in its business, the related risks and the system of internal control addressing such risks. The Auditor General and Accounts Commission consider that meeting these additional requirements is likely to be sufficient consideration of cyber security in 2022/23.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Follow up Report on External Audit Recommendations**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

Ahead of the 2022/23 External Audit Process, this paper provides a final progress report against the recommendations from the External Audit Annual Report on the 2021/22 Accounts.

2.2 Background

The table below sets out the external audit recommendations and the agreed management actions along with anticipated timings.

2021/22 recommendations

Issue/risk	Recommendation	Agreed management action/timing
1. **Integration Joint Board adjustments** A considerable amount of time was spent by the auditors in agreeing IJB figures in the draft accounts to the ledger and the IJB draft accounts due to the lack of supporting schedules provided by Management and issues with the accounting for the movement in NHS Fife's share of surpluses resulted in a significant adjustment in the audited accounts. Risk – the figures in the accounts submitted for audit do not agree to the ledger or IJB accounts.	IJB figures should be supported by detailed working papers and early agreement of figures in the accounts should be obtained from the IJB. Paragraph 18	Whilst the adjustment was significant it resulted from a technical accounting interpretation and did not arise from an error in the overall calculation of the cumulative share. Management will ensure that the correct treatment for any future in year IJB reserves are correctly presented. **Responsible officer: Margo McGurk** **Agreed date 31 December 2022**
2. Year end accruals During our audit testing, we identified a number of accruals where audit evidence could be improved and, in some cases, we believe that evidence was insufficient to support a year end accrual, but this did not represent a risk of material misstatement. Risk – Accruals and expenditure may be overstated	Management should implement controls to ensure all year end accruals are valid and adequately supported by working papers. Paragraph 18	Management will ensure that sufficient evidence for any future accruals is retained. **Responsible officer: Margo McGurk** **Agreed date 31 March 2023**

3. Financial sustainability – unidentified savings NHS Fife's 2022/23 financial plan was approved by the Board on 22 March 2022. The plan identifies a funding gap of £24 million (2021/22 £22 million), £14 million of which is to be met by identified efficiency savings of £12 million and a transfer from capital to revenue of £2 million. The forecast year- end financial position is a deficit of £10 million. Risk – Continued reliance on non-recurring savings and support from the Scottish Government presents a risk to future financial sustainability.	NHS Fife should ensure that savings plans are developed identifying how the £10 million of unidentified savings in 2022/23 will be achieved. Paragraph 53	The FIS Programme clearly focuses in the initial year on delivering a sustained and recurring level of cost improvement/saving. There is a very deliberate shift away from reliance on non-recurring savings and support from the Scottish Government. It is critical that there is a deliverable plan in place which there is for the £14 million described in this section. We are working also on a Pipeline of additional schemes which may be able to be accelerated this financial year. The focus importantly is on delivering financial balance sustainably over the medium term and this is the approach NHS Fife is embedding. There is also the added challenge that there are no UK consequentials for Covid in 2022/23 which will challenge the ability of the Board to improve on the £14 million even further. Whilst Scottish Government have made good progress in allocating resources early in the financial year there are still occasions when this does not happen and therefore the challenge locally in allocating and spending in-year. **Responsible officer: Margo McGurk** **Agreed date 30 September 2022**
b/f 1. Holiday pay accrual	NHS Fife should continue to develop the process used to calculate the accrual to ensure the medical and dental estimate is based on returns from a variety of services, reducing the risk that the estimate is subject to significant uncertainty.	**In Progress** Management will continue to develop the process to improve the accuracy of reporting. **Revised action: Margo McGurk** **Responsible officer** **Revised date 31 March 2023**

b/f 2. Discounting of annual medical negligence payments	The duration of the annual cost commitment is subject to significant uncertainty and is reimbursed to NHS Fife via the CNORIS scheme. The application of discount factors to the ongoing payment should be reviewed by 31 March 2022.	**Complete**
b/f 3. Recruitment of payroll staff	Recruitment issues in payroll services need to be addressed to prevent wider risks to service provision.	**In progress** In January 2022, a formal business case was agreed by the Board for NHS Fife to join the South East Scotland Payroll Consortium. This is made up of eight NHS Boards and NHS NSS will become the single employer of Payroll Services across these Boards. The provisional date for NHS Fife payroll staff being transferred to NHS NSS is 1 November 2022.
b/f 4. Savings for 2021/22 still need to be identified	NHS Fife needs to prepare contingency plans if the unachieved legacy gap is not to be funded by the Scottish Government.	**Complete**
b/f 5. Transformation	We have noted progress with the development of a Financial Improvement and Sustainability (FIS) Programme. This has been established to set up projects to ensure long term financial improvement and sustainability in NHS Fife. Its objectives include establishing a clear medium term financial plan and developing savings plans for 2022/23. NHS Fife needs to accelerate transformation by ensuring it is embedded within the FIS Programme and the development of a new Health and Wellbeing Strategy for Fife. Paragraph 59	**In progress** Over the past 15 months, NHS Fife has demonstrated its commitment to the transformation agenda and has taken positive steps to identify initiatives and invest in new technology to improve performance in the future

2.3 Assessment

Progress continues towards the 2021/22 External audit recommendations as well as those continued from 2020/21 and progress can be summarised as follows:

1 – Integration Joint Board adjustments

The technical accounting treatment of Integrated Joint Board reserves is understood and will be able to be appropriately accounted for in the 2022/23 Annual Accounts process should a surplus again be reported. In addition, there has been an increased senior financial resource committed to monitoring NHS Fife's interest in the IJB and as a result the year end position will be understood on a timelier basis. Conformation has since been received from the IJB, in order to populate the Annual Accounts Year End Timetable, that the balances for consolidation will be provided no later than 21st April 2023.

2 – Year End Accruals

The relevant members of the Finance Team have been briefed on the audit feedback with regards to the expected supporting evidence for any future accruals. Ahead of the 2022/23 External Audit process this point was discussed in the January Senior Finance Team meeting and the members have taken the action to reiterate this requirement across their relevant teams.

3 – Financial Sustainability – unidentified savings

The Financial Plan at the start of 2022/23 which includes a programme of Financial Improvement and Sustainability aims to deliver £12.7m of savings in 2022/23. The Financial Improvement and Sustainability Programme continues to drive financial improvement across the organisation and the programme has been aided by the recruitment of a senior Finance Manager to support the progress.

As of 11th November, the Scottish Government have requested NHS Fife deliver its financial plan which reflects a financial gap of £10.4m as a minimum, at the financial year end. Scottish Government have confirmed that they are returning to their 2018 commitment in relation to the Medium-Term Financial Framework regarding a three-year reporting period to deliver financial balance. A three-year financial plan was submitted to the Scottish Government in August detailing our plans to achieve financial balance by the end of the three-year period under review.

Ahead of the 2023/24 Financial Year, priority areas of focus and potential savings have been discussed between Scottish Government and the Boards, and plans are being developed to investigate these options along with increased regional collaboration.

b/f1 – Holiday Pay Accrual

Whilst the process for calculating and ensuring sufficient coverage remains the same. Management continues to proactively engage with the services to ensure that any known uncertainties are minimised where possible.

b/f3 – Recruitment of Payroll Staff

As of February 1st, the NHS Fife Payroll Team were TUPE transferred over to NSS to form part of the South East Payroll Consortium. One of the main objectives of this project is to increase service

stability to the payroll functions of the partner boards. It is anticipated that the recruitment and retention of payroll officers will improve over the coming years brining greater resilience to the payroll function for the benefit of NHS Fife staff.

b/f5 - Transformation

Transformation retains its place on the NHS Fife agenda and is being focused on as part of the 2022/23 SPRA process and the development of the new Population Health and Wellbeing Strategy.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The External Annual Accounts Audit report was widely shared with members of the Finance directorate to ensure that lessons were learned from any areas brought to attention during the 2021/22 process.

2.3.3 Financial

The Financial Risks and the need to ensure an appropriate response has been widely communicated and continues to be monitored across the Directorate.

2.3.4 Risk Assessment/Management

It is important to ensure that all audit recommendations receive appropriate attention to ensure risks associated with them can be managed timeously.

2.3.5 Equality and Diversity, including health inequalities

A separate EDA has not been completed in relation to this report however the financial planning and financial governance arrangements in place across the organisation include the appropriate assessments.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Updates on the progress towards the 2021/22 Audit recommendation have been formed following consultations with relevant members of the finance Directorate.

2.3.8 Route to the Meeting

A previous update on the progress towards the 2021/22 External Audit Recommendations was provided to the Audit & Risk committee on 5th December 2022.

2.4 Recommendation

The Audit & Risk committee is asked to take assurance from the progress made against the 2021/22 External Audit recommendations.

3 List of appendices

N/A

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

Fife Health Board Patients' Private Funds Audit Planning Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2023

Introduction

Purpose and Scope

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The purpose of this report is to provide the Board (as those charged with the governance of Fife Health Board Patients Private Funds) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Board with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

Over recent years there have been a number of developments in the auditing and financial reporting framework. We have provided details of these developments in the Audit Planning Memorandum for the Fife Health Charity.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2023. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

As part of our quality control procedures, we review and update our Letters of Engagement on a regular basis. As there has been a change of the Director of Finance, we have issued an updated Engagement Letter. An electronic copy of this Engagement Letter is shown at Appendix 1. As detailed in our Engagement Letter, it remains effective until it is replaced.

Independence

We can confirm that Thomson Cooper are independent within the context of relevant regulatory and professional requirements and that there are no circumstances of which the firm is aware which might lead to impairment in the objectivity of either the audit engagement partners or audit staff.

Staff Independence

All our Staff must adhere to strict regulatory, professional and internal independence requirements related to investments or business relationships with clients. All staff and partners must certify their compliance with independence rules on an annual basis. Thomson Cooper is authorised by ICAS to carry out statutory audits. Members of ICAS and other Accounting Bodies are bound by the Ethical Code which covers, objectivity, independence, confidentiality and integrity.

Money Laundering Regulations

All our staff are briefed in the current Money Laundering Regulations. As part of these regulations, and determining the risk to our audit, we consider the nature of your business, where you operate, your products and services and the appropriateness of your internal controls.

Quality

Independent quality reviews of our audit work are performed throughout the year. The reviews include testing of the effectiveness and quality of our audit work and we maintain a continuous improvement programme to ensure that our standards are maintained and improved. In addition, external reviews are also carried out periodically by the Institute of Chartered Accountants of Scotland (ICAS).

We are members of Accelerate, a community of relationship-focused, technology-driven, value-based accounting firms. Accelerate is a Business Associate of Crowe Global, meaning we can access accounting firms in more than 130 countries throughout the world. As part of that membership we receive visits every two years to review our audit approach and to discuss current auditing issues. Accelerate also provides technical courses and material on auditing throughout the year.

All Audit Staff undertake ongoing Continuous Professional Development via attendance at internal and external training courses and seminars.

Background to Appointment (continued)

Ethical Standards

Part 3 of the Revised Ethical Standard 2019 issued by the Financial Reporting Council looks at 'Long Association with Engagements'. Where partners and staff in senior positions have a long association, a familiarity threat to integrity and objectivity of that person may exist. In order to safeguard against such threats, the firm is required to apply appropriate safeguards. These safeguards could include rotating the audit partner by appointing another partner with no previous involvement as a Responsible Individual (RI) with the entity, rotating senior members of the audit team, involving an additional partner who has not previously been a member of the engagement team to advise or arranging an engagement quality review of the audit.

Subject to board approval, it is suggested Alan Mitchell will be retained as the RI and Fiona Haro, another RI within the firm, will undertake a concurring review.

Alan Mitchell has been the Responsible Individual (RI) for 10 years, however over this time the composition of the Board of Trustees has changed and the audit manager in charge of the audit fieldwork has changed. The RI is involved in the direction of the audit and supervises all work conducted, however the RI does not perform any of the audit fieldwork. All audit work is carried out by a qualified accountant.

Part 5 of the Ethical Standard issued by the Financial Reporting Council limits the range of services auditors can provide. At present, we assist in the preparation of the Statutory Accounts as required. There is no need to disclose this in the financial statements if the company has "informed management". Based on the knowledge and experience of the Trustees, we are satisfied that Fife Health Board Patients' Private Funds has "informed management" and therefore no disclosures will be required in the financial statements.

ISA (UK) 315 (Revised July 2020) - Identifying and Assessing the Risks of Material Misstatement

Following the revision to ISA 315 (effective for accounting periods commencing on or after 15 December 2021) we are required to perform additional procedures in relation to Information Technology and its impact on the audit. The additional work focusses on the auditor obtaining an understanding of the entity's control environment and how this interacts with their system of internal controls. As part of our audit, we will document our understanding of the IT control environment and identify where we believe the risk for potential misstatement may occur.

Further details of the revised ISA can be found at point 1 within appendix 1.

Thomson Cooper Audit Approach

General

Thomson Cooper adopts a risk-based approach to audit assignments.

The starting point for each assignment is to identify the key issues and risks facing the organisation including a review of internal control strengths and weaknesses. This involves close liaison with clients in order to obtain a good understanding of the client's business before detailed audit work commences.

Following this initial assessment, the audit work to be undertaken can be fully planned.

Effective planning facilitates:

- concentration of audit effort in areas of high risk;
- maximisation of overall efficiencies in audit work; and
- the drawing of suitable conclusions concerning the truth and fairness of the financial statements.

Detailed Audit Procedures

The extent of testing undertaken on the detailed records depends upon the continued adequacy of key internal accounting and operational controls, the materiality of the item involved, and the information and support provided by management.

Detailed audit testing will be performed to test the reliability of the accounting system in operation and to provide additional audit assurance.

Relationship with Internal Audit

Introduction

NHS Fife has an internal audit service which conducts periodic reviews of the Patients' Private Funds.

International Standard on Auditing 610 (ISA 610) entitled "Considering the Work of Internal Audit" establishes standards and provides guidance to external auditors in considering the work of internal audit. The standard requires external auditors to "consider the activities of internal auditing and their affect, if any, on external audit procedures".

The following sets out our audit approach for the current year and our relationship with NHS Fife internal audit function.

International Standard on Auditing 610

As stated above, the standard requires the auditor to consider the activities of internal audit. Section 5 of the standard indicates that internal audit normally has specific regard to the following:-

1. Monitoring of internal control.
2. Examination of financial and operating information.
3. Review of the efficiency and effectiveness of operations including non financial controls.
4. Review of compliance with laws and regulations.

The role of internal audit is set by management and clearly its objectives will differ from the external auditor whose appointment is to report independently on the annual financial statements. The standard recognises, however, that some of the means of achieving the respective objectives are similar and therefore certain aspect of internal audit work may be useful in determining the nature, timing and extent of external audit procedures. It follows therefore that we are obliged to obtain a sufficient understanding of the work carried out by internal audit to enable us to identify and assess the risks of material misstatements of the financial statements and accordingly to design and perform further audit procedures.

Based on our review of the work carried out by NHS Internal Audit Service in previous years, the principal area upon which we can place reliance on the work of internal audit function, has been in relation to the overall control environment within which the Patients' Private Funds operates.

The process of communication between external and internal auditors is two way and we will ensure that any instances of non compliance with the Financial Operating Procedures detected during our external audit work are brought to the attention of internal audit. The Board are asked to note and confirm their approval with the way in which we intend working with internal audit.

Staffing

Partner in Charge of Assignment

The audit engagement partner is Alan Mitchell. This is Alan's 10th year as lead. In accordance with Section 3 of the Ethical Standard, safeguards are in place to ensure objectivity and independence is not impaired.

Details of the safeguards in place are set out on page 3.

Alan will sign the Audit Report as Senior Statutory Auditor on behalf of Thomson Cooper.

Other Staff

In order to maximise efficiency and minimise disruption to the company, the firm, as far as possible will try to maintain continuity in the other staff deployed on the assignment.

Staff members involved in the audit have previous experience of the assignment and are suitably qualified and trained.

The senior staff member this year is Billy Leitch, a qualified Accountant. He will be assisted by Lauren Halford who is a part qualified Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

Thomson Cooper aim to plan and perform sufficient audit work so as to ensure that detection risk is minimised, and that the conclusion drawn regarding the truth and fairness of Fife Health Board Patients Private Fund's accounts is valid.

This involves Thomson Cooper in a wide evaluation of risk areas (per ISA 300 - Planning, ISA 250A – Consideration of Laws and Regulations and ISA 330 - Auditor's Response to Assessed Risks) and also a detailed evaluation, at the level of account class, of the risk of material misstatement.

The areas detailed below have been limited to those, based on previous audit experience, which carry the highest risk of material misstatement either because the balances are so significant in the overall context of Fife Health Board Patients Private Fund's accounts or the account class is subject to a degree of estimation or relies upon the work of an expert.

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2023.

The Board remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Board of Fife Health Board Patients' Private Funds reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Board Patients' Private Funds at 31 March 2023. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Patients Funds

Due to the nature of the fund's assets i.e. cash, there is an increased susceptibility of the assets to loss through theft or misappropriation. A key focus of our audit will be the testing of the adequacy of the controls in place governing the security of patient funds on the wards.

Compliance with Agreed Operating Procedures

The Board has in place a series of control and authorisation procedures for patient funds which are documented in the Board's Financial Operating Procedure. This report details the various forms which should be used by staff in order to adequately record and control patient funds on the wards and is a key source of internal control. Our audit will include tests to assess the extent to which members of staff have adhered to the documented procedures, including visiting various hospital wards on a rotational basis (see Appendix 2).

We shall also consider any areas of potential non-compliance with procedures that were identified and communicated to the Board in the previous year's audit and follow up with regard to how each item has been subsequently dealt with. In addition, where considered relevant, we will seek to re-visit any wards attended in the previous year where issues were identified to perform updated tests to re-assess the extent to which staff have been advised of the issues and have acted upon the recommendations.

Management Override

In every organisation, senior management may be in a position to override the routine day-to-day financial controls. For all of our audits, we consider this risk and adapt our audit procedures accordingly.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

Audit Risks (continued)

Fraud (continued)

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity;
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour; and
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Board as soon as practicable.

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Board acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Materiality

Concept and definition

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

- According to International Standard on Auditing 320 Audit Materiality, 'misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; and judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both'.

  The Clarified ISA 320 on Audit Materiality establishes the concept of 'performance materiality'. Performance materiality means the amounts set by the auditor at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

An item may also be considered material for reasons other than size, if for example, it had an impact on:

- trends;
- compliance with loan covenants; or
- instances when greater precision is required.

Calculation and determination

We have determined materiality based on professional judgement in the context of our knowledge of Fife Health Board Patients' Private Funds, including consideration of factors such as member expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality in order to:

- estimate the tolerable level of misstatement in the financial statements;
- assist in establishing the scope of our audit engagement and audit tests;
- calculate sample sizes; and
- assist in evaluating the effect of known and likely misstatements on the financial statements.

We will finalise our materiality figure prior to the commencement of our audit.

Materiality (continued)

If, in the specific circumstances of Fife Health Board Patients' Private Funds, we believe there are particular transactions, account balances or disclosures where misstatement of less than materiality for the financial statements as a whole could be expected to influence the decisions of the users, we shall also determine the performance materiality level to be applied to those particular transactions.

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Board all unadjusted items identified during our audit, other than those which we believe are "clearly trivial".

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of 'clearly trivial', however, we consider the 'clearly trivial' limit to be less than 1% of materiality.

We will obtain written representations from the Board confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Board should the need arise. Audit findings will be communicated orally at the meeting of the Board at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Board for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Board. If, after discussion, there remain any material unadjusted misstatements written representation from the Board may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Board where it is believed that an awareness is required for the Board to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Timetable

	Date
Issue Bank Confirmation Letter	20 March 2023
Audit Planning Meeting with Client	6 March 2023
Issue Audit Planning Memorandum	8 March 2023
Audit Staff Planning Meeting	1 May 2023
Audit Fieldwork Commences	2 May 2023
Audit Clearance Meeting	WC 29 May 2023
Provide Completion Documents	2 June 2023
Board Papers Issued	2 June 2023
Audit Committee Meeting	23 June 2023
Board Meeting	23 June 2023

Proposed Fees

	Proposed 2023	Actual 2022
	£	£
On completion of audit fieldwork	2,150	1,800
On signing of accounts	1,000	900
	3,150	2,700

Should we anticipate that our costs will exceed our budget due to additional work that we may require to undertake, we shall notify you immediately in order that we may agree what action, if any, is required by you and to agree the basis for any additional charges.

The above fees are exclusive of VAT and expenses.

Appendix 1 – Engagement Letter

An electronic copy of our newly issued Engagement Letter is as follows:

CF15B.1537854.KC

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24 March 2021

The Trustees
Fife Health Board Patients' Private Fund
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Trustees

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Margo McGurk is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Board Patients' Private Fund

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.6 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.7 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.8 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.9 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.10 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.11 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.12 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.13 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

24 March 2021

Thomson Cooper

Appendix 2 – Hospitals Visited

Hospital	Gross Receipts	2015	2016	2017	2018	2019	2020	2021	2022	Proposed 2023
Adamson	-									
Levenmouth	298	✓				✓	✓			
Lynebank	93,656		✓		✓	✓		✓	✓	
Queen Margaret *	6,827		✓					✓		
St Andrews	-									
Stratheden	71,091	✓		✓	✓		✓		✓	✓
Whyteman's Brae	5,358			✓						✓

* Excludes "QM Acute" of £25,902

Gross Receipts are based on the figures from the accounts for the year ended 31 March 2022.

Note : Queen Margaret will also be visited to review and test the art catalogue

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Audit Scotland Technical Bulletin 2022/4**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2022/4 is a resource shared across members of the Finance Directorate and is provided to the Audit and Risk committee to raise awareness of emerging developments from an Audit perspective.

2.2 Background

The Audit Scotland Technical Bulletins are prepared on a quarterly basis and are provided to support auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- Information on the main technical developments across the public sector in the quarter.
- Information on professional matters during the quarter that are expected to have applicability to the public sector.

- Summaries of responses to any requests from auditors for technical consultations with Audit Scotland Professional Support.

2.3 Assessment

The Audit Scotland Technical Bulletin 2022/4 is arranged by sector with content applicable to specific sectors and also across the public sector as a whole.

Chapter two is of reference to all public sector bodies and included within this section is clarification of the change relating to the target submission dates for the Audited Annual Accounts for the Health Sector (30 June) being brought forward.

From a Health Board perspective Chapter five focuses on a review of the 2021/22 Independent Auditors Report and highlights the findings and specific areas for Auditors improvements ahead of the 2022/23 Audit assignments.

In addition, chapter six focuses on fraud and irregularities and provides an example of a recently identified fraud in the education sector. Although not within the Healthcare sector this example highlights the need to ensure internal controls remain sufficient and are routinely reviewed within NHS Fife.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Technical Bulletin is shared widely across the Finance Directorate.

2.3.3 Financial

Technical and Financial developments are addressed from Audit Scotland's perspective.

2.3.4 Risk Assessment/Management

Emerging Risks relating to the Health Sector are addressed from Audit Scotland's perspective.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Audit Scotland Technical Bulletins are provided to Boards through the Technical Accounts Group meetings and any impending issues are discussed.

2.3.8 Route to the Meeting

This paper has been provided following discussions between the Head of Corporate Governance and the Head of Financial Services & Procurement

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix, Audit Scotland Technical Bulletin 2022/4

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

Technical Bulletin 2022/4

Technical developments and emerging risks from October to December 2022

AUDIT SCOTLAND

Prepared by Audit Scotland for appointed auditors and audited bodies in all sectors

14 December 2022

Contents

1: Introduction

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Purpose

The purpose of Technical Bulletins from Audit Scotland's Professional Support is to provide auditors appointed by the Auditor General and Accounts Commission with:

- information on the main technical developments in each sector during the quarter
- information on professional matters during the quarter that are expected to have applicability to the public sector
- summaries of responses to requests from auditors for technical consultations with Professional Support.

Appointed auditors are required by the Code of Audit Practice to pay due regard to Technical Bulletins. The information on technical developments is aimed at highlighting the key points that Professional Support considers auditors in the Scottish public sector require generally to be aware of. It may still be necessary for auditors to read the source material if greater detail is required in the circumstances of a specific audited body. Source material can be accessed by using the hyperlinks, where provided.

Any specific actions that Professional Support recommends that auditors take are highlighted in green.

Technical Bulletins are also published on the Audit Scotland website and therefore are available for audited bodies and other stakeholders to access. However, hyperlinks to source material indicated with an asterisk (*) link to files on Audit Scotland's SharePoint* and are only accessible by auditors.

Highlighted items

The following table highlights a selection of items in this Technical Bulletin:

Highlighted items		
Professional Support has published guidance on planning 2022/23 annual audits [see paragraph 1]	Audit Scotland has issued guidance to supplement specific areas in the Code of Audit Practice [see paragraph 6]	The Auditor General has issued a briefing on the challenges and risks faced by Scotland's public finances [see paragraph 7]
Professional Support has published guidance on risks of misstatement in the 2022/23 annual accounts of local government bodies [see paragraph 9]	The Scottish Government has permitted flexibilities to help fund the local government pay award for 2022/23 [see paragraph 13]	The Scottish Government has issued a consultation draft of revised statutory guidance on accounting for capital grant [see paragraph 16]
CIPFA/LASAAC has issued an update to the accounting code for England and Wales [see paragraph 18]	CIPFA has issued revised guidance on audit committees for local authorities [see paragraph 21]	Professional Support has issued a report on a review of the 2021/22 IARs of health boards [see paragraph 32]
The FRC has issued a report on creating an audit environment that enables professional scepticism and challenge [see paragraph 37]	The FRC has issued a report on drivers and barriers to auditors exercising professional scepticism [see paragraph 40]	The FRC has issued a revised ISA (UK) 600 on group audits [see paragraph 44]
The IAASB has issued an exposure draft of proposed revisions to ISA 500 on audit evidence [see paragraph 56]	The FRC has issued a report on audit quality inspections of local audits in England [see paragraph 59]	The IAASB has issued guidance on the impact on ISAs of an amendment to IAS 1 [see paragraph 62]
The FRC has issued a report on disclosures related to net zero targets [see paragraph 66]	The FRC has issued a report that sets out the attributes of a good annual report and accounts [see paragraph 69]	The FRC has issued a report on a review of the corporate reporting of companies [see paragraph 78]

2: All sectors

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Guidance on planning 2022/23 annual audits

1. Professional Support has issued guidance to assist all appointed auditors in planning their 2022/23 annual audits of public bodies. The guidance supplements the Code of Audit Practice (2021) and sets out the range of core annual audit activity and related outputs required for 2022/23, and the timescales for completing the audit in each sector.

2. Auditors should comply with the guidance when planning, performing and reporting their 2022/23 audits. The guidance is accessible by auditors with other supporting materials on SharePoint* but it is also freely available from the Audit Scotland website.

3. The largest component of core annual audit activity is the audit of a public body's annual accounts. However, the audit of the annual accounts has a wider scope than the private sector, and requires conclusions on aspects of public bodies' arrangements and performance. In local government, public audit includes considering arrangements to secure Best Value and community planning and publishing performance information. Auditors also provide important intelligence to the Auditor General, Accounts Commission and Audit Scotland in areas where they are best placed to do so.

4. 2022/23 year is the first year of the new five-year audit appointments. Audit Scotland's policy is not to compromise on audit quality or the wellbeing of audit teams, but that timescales are negotiable. The guidance is intended to strike the right balance in 2022/23 between ambitions for public audit and the capacity for auditors to carry out the work to the appropriate high quality. Target audit completion dates are considered to be stretching but achievable for the majority of audits.

5. The following table provides a summary of the key changes from last year, along with the paragraphs of the guidance in which further information is provided:

Nature of change	Paragraph
The level of expected fees below which auditors may negotiate an increase to auditor remuneration by up to 20% has increased to £35,000.	13
The target date for submitting Annual Audit Plans to Audit Scotland for central government and health has moved back one month to 31 March.	20
Guidance has been provided on the new requirement of the Code of Audit Practice to report key audit matters in the Annual Audit Report.	55 to 57

Nature of change	Paragraph
The target submission dates for the audited annual accounts have been brought forward for local government (30 September) and health (30 June).	61
Guidance has been added on specific wider-scope audit work required on climate change.	76 to 81
Guidance has been added on considering risks related to cyber security.	82 to 85
Guidance has been updated to reflect the new approach to auditing Best Value.	94 to 118
Guidance on grant claims and returns has been updated to reflect that any returns not on the approved list should be treated as non-audit services.	123 to 124
The target submission dates for the Annual Audit Reports have been brought forward for local government (30 September) and health (30 June).	211

Supplementary guidance on areas of the Code of Audit Practice

6. Audit Scotland has issued guidance to supplement specific areas in the Code of Audit Practice. The three areas, and a brief summary of the supplementary guidance related to each, are set out in the following table:

Area	Summary of supplementary guidance
Wider scope of public audit	The guidance sets out example questions at Appendix 1 to assist auditors when carrying out their risk assessment and planning their wider scope audit work.
Criteria to be used when identifying a less complex body	The wider scope audit in a less complex body may be limited to concluding on its financial sustainability. A body with gross revenue, gross assets and gross liabilities less than £10.2m is likely to be less complex. A body should not be treated as less complex where the: • auditor identifies any wider scope risks beyond financial sustainability • body has been subject to a statutory report in the previous year that related to wider scope issues • body is of strategic importance to the Auditor General or Accounts Commission. The guidance requires auditors to: • assess whether a body is less complex as part of planning each year, and document their assessment • explain in the Annual Audit Plan that the body is judged to have met the criteria to be treated as less complex • confirm in the Annual Audit Report that the audit was completed under the less complex body arrangements.

Area	Summary of supplementary guidance
Best Value	The guidance assists auditors to integrate Best Value with the wider scope annual audit work.

Briefing on public finances

7. The Auditor General has issued a briefing on the challenges and risks faced by Scotland's public finances. The briefing:

- focuses on the pressures facing the Scottish budget in 2022/23 and in the medium term, and the implications for public services
- informs and supports scrutiny of proposed spending and tax plans
- emphasises the need for reform to public services.

8. Some key messages from the briefing are summarised in the following table:

Key message	Considerations
Rising costs and increasing demands mean that the Scottish Government has to manage its position to avoid the risk that it overspends on the 2022/23 budget.	The current high level of inflation means that the Scottish Government faces higher public-sector pay and other costs, at the same time as it faces increasing demand for support from people impacted by the cost-of-living crisis. Any overspend by the Scottish Government in 2022/23 could be clawed back from the 2023/24 budget.
The Scottish Government has limited ability to make changes to balance the 2022/23 budget, and will face difficult choices setting the 2023/24 budget.	Within the year, much of the Scottish budget is committed, which means that there is limited flexibility available to the Scottish Government in the short term. In setting the 2023/24 budget, the Scottish Government needs to balance short-term necessities with longer-term priorities.
The pace and scale of reform required across the public sector needs to increase.	Immediate events and financial pressures must not distract from the immediate need for broader reform. In the past, the Auditor General has highlighted an implementation gap between the Scottish Government's ambitions for reform and delivery on the ground.

3: Local government sector

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

TGN on risks of misstatement in 2022/23

9. Professional Support has published Technical Guidance Note (TGN) 2022/8(LG) to provide auditors with guidance on risks of misstatement in the 2022/23 annual accounts of local government bodies. The TGN is accessible by auditors on SharePoint*, along with supporting material, and is also available from the Audit Scotland website.

10. The TGN is intended to inform auditors' judgement when identifying and assessing the risks of material misstatement. The TGN supplements the Code of Audit Practice and auditors are expected to pay it due regard and use it as a primary reference source when performing 2022/23 audits. Auditors should advise Professional Support of any intended departures from the guidance.

11. The TGN comprises a number of modules as summarised in the following table:

Module	Risks of misstatement area	Purpose
Overview	Areas that are pervasive to the financial statements as a whole	Explains the appropriate related accounting treatment and sets out the action auditors should undertake to evaluate whether the body has followed the required treatment
1 - 9	Specific classes of transactions, balances and disclosures in the financial statements.	
10	Audited part of the Remuneration Report	Explains the requirements and sets out the action auditors should undertake
11	Statutory Other Information (e.g. Management Commentary and Annual Governance Statement)	Sets out the procedures for considering the Statutory Other Information
12	Integration joint boards	Provides guidance on the application of the above modules to these specific bodies
13	Pension fund accounts	
14	Section 106 charities	

12. The risks of misstatement reflect areas of complexity, subjectivity and uncertainty. They have been updated to reflect new requirements and risks which emerged during the 2021/22 audits that remain applicable. A separate note* summarises the main changes from 2021/22.

Flexibilities to fund 2022/23 pay award

13. The Scottish Government has sent a letter* to the Convention of Scottish Local Authorities (CoSLA) setting out permitted flexibilities to help fund the local government pay award for 2022/23. The flexibilities are intended to enable local authorities to replace Capital Financed from Current Revenue (CFCR) or other revenue reserves with the additional capital grant in 2022/23 and 2023/24 to allow the release of such revenue resources for use towards the pay award.

14. The flexibilities are summarised in the following table:

Area	Use of additional capital grant
Early Learning & Childcare funding (ELC)	To be substituted for existing ELC revenue funding currently ring-fenced to support capital projects. The grant award letter is to be amended to permit the release of ring-fenced revenue funding.
Affordable Housing Capital Programme	To be used to substitute for revenue reserves earmarked for the capital programme for affordable housing in order to release those reserves.
CFCR in Housing Revenue Account (HRA)	To be substituted for CFCR for HRA capital investment, allowing an equal amount of reserves to be released from the HRA.

15. Other flexibilities requested by CoSLA (such as using capital receipts to meet the pay award and using capital grant towards redundancy costs) are not currently permitted.

Draft revised statutory guidance on accounting for capital grant

16. The Scottish Government has issued a consultation draft* of statutory guidance which will adapt Finance Circular 3/2018 for 2022/23 and 2023/24 to permit local authorities flexibilities in the use of the additional capital grant. This is necessary to allow the above permitted flexibilities.

17. The flexibilities and the required accounting treatment are summarised in the following table:

Use of grant	Accounting
Fund loans fund repayments	The element of capital grant applied to the repayment of the principal of loans will be held within the General Fund and used to meet the loan repayments. Any capital grant not utilised by 31 March requires to be transferred from the General Fund to either the Capital Grants Unapplied Account or the Capital Adjustment Account.

Use of grant	Accounting
Replace reserves currently earmarked for capital investment in affordable housing in order to release an equivalent amount for use towards the pay award	Once the grant is utilised to meet capital investment in affordable housing it will be transferred from the General Fund to the Capital Adjustment Account.
Fund capital investment in the housing capital programme	The capital grant may replace housing CFCR or other revenue reserves which will generate a surplus on the Housing Revenue Account which may be released to the General Fund for use towards the pay award. Once the grant is utilised it will be transferred from the General Fund to the Capital Adjustment Account.

Update to accounting code

18. The CIPFA/LASAAC Local Authority Code Board has issued an update to the Code of Practice on Local Authority Accounting in the UK (accounting code). The update applies to England and Wales from 2021/22 until 2024/25.

19. The key change in the update is a temporary relief so that local authorities in England and Wales are not required to report the gross book value and accumulated depreciation for infrastructure assets. Where a local authority chooses to apply this temporary relief, the update requires information to be disclosed to explain an authority's rationale for this decision.

20. The scope of the update does not currently apply to Scottish local authorities as Finance Circular 9/2022 already overrides the relevant disclosure requirement (see Technical Bulletin 2022/3 – paragraph 11). However, the override lasts until 2023/24 and the application of the update to Scotland may be reconsidered in respect of 2024/25.

Revised guidance on audit committees

21. The Charted Institute of Public Finance and Accountancy (CIPFA) has issued revised guidance* on audit committees for local authorities. The revised guidance builds on the 2018 edition but targets the guidance at committee members and those who support them.

22. The Delivering Good Governance in Local Government Framework lists undertaking the core functions of an audit committee, as identified in this guidance, as a key element of an authority's governance arrangements.

23. The guidance comprises the following discrete sections:

- CIPFA audit committees position statement.
- Guidance for committee members in local authorities.

- Guidance for members of police audit committees.
- A supplement aimed at those who support the committee.

24. There are also various appendices including a self-assessment checklist.

25. The position statement represents CIPFA's view on the audit committee practice and principles that local authorities in the UK should adopt. Some key elements are summarised in the following table:

Element	Summary of statement
Purpose of the audit committee	The purpose of audit committees is to provide an independent and high-level focus on the adequacy of governance, risk and control arrangements in the local authority.
Independence	The audit committee should be independent of executive decision making and able to provide objective oversight.
Core functions	Specific functions should include: • being satisfied that the authority's Annual Governance Statement properly reflects the risk environment, and any improvement actions required, and demonstrate how governance supports the achievement of the authority's objectives • supporting the maintenance of effective arrangements for financial reporting • considering the arrangements in place to secure adequate assurance across the authority's full range of operations and collaborations with other entities • overseeing the authority's internal audit function • considering the opinions, reports and recommendations of external audit.
Effective Chair	Key personal skills for an effective audit committee chair include: • promoting apolitical open discussion • unbiased attitudes, and treating auditors, the executive and management fairly • the ability to challenge the executive and senior managers when required.
Membership	The members should be trained to fulfil their role. CIPFA recommends that each audit committee should include at least two co-opted independent members.

Element	Summary of statement
Operation	To discharge its responsibilities effectively, the committee should: • meet at least four times a year • be able to meet privately and separately with the external auditor and with the head of internal audit • report regularly on its work to those charged with governance • report annually in public on how the committee has complied with the position statement • annually self-assess its performance. • evaluate its impact and identify areas for improvement.

4: Central government sector

Contact: Neil Cameron, NCameron@audit-scotland.gov.uk

2022/23 discount rates

26. HM Treasury has issued PES (2022)08* to announce changes in the discount rates for general provisions, post-employment benefit liabilities, leases, and financial instruments as at 31 March 2023.

General provisions

27. The nominal discount rates to be applied as at 31 March 2023 for discounting general provisions recognised under IAS 37 are set out in the following table:

Category	Period	Percentage
Short term	Within 5 years	3.27%
Medium term	Between 5 and 10 years	3.2%
Long term	Between 10 and 40 years	3.51%
Very long term	More than 40 years	3.0%

28. As nominal rates do not take inflation into account, cash flows require to be inflated separately. There is a rebuttable assumption that the inflation rates specified in the paper will be used (unless other rates are clearly more applicable). The specified rates are:

- 7.4% for up to one year from the year end
- 0.6% between one and two years
- 2% for after two years.

Post-employment benefits

29. The discount rates for post-employment benefits are set out in the following table:

Use	Rate from 31 March 2023
Real rate used for valuing unfunded pension scheme liabilities and early departure provisions	1.7%

Use	Rate from 31 March 2023
Nominal rate for unwinding discount on liabilities (interest)	4.15%
Rate used for funded pension schemes	Based on returns from AA corporate bonds at 31 March

Financial instruments

30. The financial instrument discount rates to be applied at 31 March 2023 are set out in the following table:

Type		Rate
Nominal rate when financial instrument is not linked to an inflationary index		1.9%
Real rate when financial instrument indexed to RPI	In excess of RPI:	
	Until February 2030	(1.3%)
	From February 2030	(0.2%)

Leases

31. Where a body cannot determine the interest rate implicit in the lease, they are required to use a nominal lease discount rate of 3.51%. This is relevant for transition to IFRS 16 and for new leases that commence or are remeasured between 1 January 2023 and 31 December 2023.

5: Health sector

Contact: Neil Cameron, NCameron@audit-scotland.gov.uk

Review of 2021/22 IARs

32. Professional Support has issued a report* to set out findings from a review of the 2021/22 Independent Auditors' Report (IARs) of health boards. The review evaluated compliance with the model forms of IAR and application guidance provided to auditors.

33. A summary of review findings is provided at Section 1 of the report and specific areas for improvement are highlighted at Section 2. In addition, Section 3 addresses findings in respect of disclosures in the Remuneration and Staff Report that impacts on the ability of users to understand the IAR.

34. The review found a very good level of compliance with the application guidance. However, the following areas for improvement were identified by the review:

- An auditor at one health board used the board-only model instead of the model for group accounts.
- Two audit providers at six boards added around a page of text to the model wording. Each case related to the explanation of the extent to which the audit could detect irregularities. One audit provider did not consult with Professional Support on the amendments.

35. The review also identified other issues where it may not have been clear to users what statements had been audited. For example, in some cases:

- auditors did not precisely match the titles of the financial statements or other reports to those titles used by the board
- the board had not accurately or clearly identified the parts of the Remuneration and Staff Report that had been audited. This issue had previously been highlighted in Technical Bulletin 2022/2 (paragraph 9).

36. Auditors should ensure the areas for improvement are addressed for their IARs in 2022/23.

6: Professional matters

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Report on professional scepticism and challenge

37. The Financial Reporting Council (FRC) has issued a report that sets out the key attributes of a high-quality audit environment that enable professional scepticism and challenge.

38. Professional scepticism is an attitude that includes a questioning mind, being alert to conditions which may indicate possible misstatement due to error or fraud, and a critical assessment of audit evidence. A fundamental attribute of an auditor's mindset and behaviour is exercising professional scepticism and challenge as these are the foundations of a high-quality audit. The inconsistent application of scepticism and challenge results in the poor application of professional judgement.

39. The paper considers four key elements of an environment that enable scepticism and challenge. They are summarised in the following table:

Element	Requirements	Achieved by	Example of actions
Learning environment	An auditor needs to be equipped with the skills and expertise necessary to exercise professional scepticism and challenge the management of an audited entity.	Professional qualification and ongoing learning and development, including on-the job coaching.	Training in behaviours and mindset alongside technical training. Audit-based learning and coaching, built into an auditor's workload. Training in soft skills such as critical thinking and handling difficult conversations.
Culture	An audit firm needs to encourage auditors to display scepticism and challenge.	A culture that promotes and nurtures these behaviours including the elimination of barriers.	Communication of expected behaviours using a variety of formats. Promoting 'speaking up'. A culture of continual improvement and learning from mistakes. Engagement with employees to become advocates of desired behaviours.

Element	Requirements	Achieved by	Example of actions
Audit firm operating model	An audit firm needs to enable auditors to apply scepticism and challenge in their day-to-day audit work through the firm's operating model and processes.	Appropriate resources and processes at the audit firm including 'hot' reviews and a culture of consultation.	Sufficient and appropriate resources on every audit with strong project management. Effective use of specialists, experts and central technical teams to provide challenge in the most complex areas.
Ecosystem	Other parties in the ecosystem, including the audit committee and management at the audited entity, also play a part in enabling this mindset and behaviour.	Management and those charged with governance at the audited entities supporting these behaviours.	An engaged audit committee that supports the audit team with challenges. Management at the audited entity providing quality and timely information and engaging with the auditors to facilitate challenge.

Report on drivers and barriers to professional scepticism

40. The FRC has issued a report which is the output of research they commissioned to understand the drivers and barriers to auditors exercising professional scepticism and adequately challenging management. The research was carried out to inform the report on scepticism referred to above.

41. The research identified some key factors that encourage professional scepticism and effective challenge. Importantly, the most powerful drivers are dependent upon how staff and teams are influenced by more senior auditors (i.e. partners, directors and senior managers). Some of those factors are summarised in the following table:

Factor	Drivers
Teaching and embedding desired auditor behaviour	Bringing the specific behaviours to life through case studies and training highlighting the desired behaviours explicitly and explaining what they mean in practice. Training in soft skills, e.g. critical thinking and handling difficult conversations. Having the time and space to coach auditors by working collaboratively with them, sharing feedback, and identifying opportunities for them to be exposed to instances of scepticism and challenge in real-time work situations.
Consistently communicating and prompting desired audit behaviour	An ongoing, consistent commitment to scepticism and challenge is continually communicated and reinforced. An overall culture of continual improvement is implemented.

Factor	Drivers
Role modelling desired audit behaviour	Partners, directors and senior managers: • act as leaders in relation to scepticism and challenge, modelling these behaviours themselves • create opportunities for audit managers and junior level auditors to see them doing so in action • continually reasserting the behaviours in communications and feedback.

42. The research also highlighted the factors that can impede firms from establishing a culture that encourages auditors to consistently display the desired behaviours. They are summarised in the following table:

Factor	Barriers
Workplace environments that support desired auditor behaviour	Environments that discourage or fail to promote open, collaborative working practices. Cultural hierarchies that do not allow manager and junior level auditors to raise challenge upwards. This can be caused by a lack of transparency around the rationale behind decisions and ineffective feedback processes that do not give audit managers and junior auditors room to grow.
Resources to enable desired auditor behaviour	Time, workload, and resourcing pressures that squeeze out the time and space needed for auditors to be able to exercise scepticism and challenge, and apply the critical thinking needed for good judgement.
Alignment of reward and recognition with desired auditor behaviour	Inconsistencies in the extent to which the behaviours are explicitly linked to remuneration, reward, progression, and feedback.

43. Alongside these key drivers and barriers, the research also identified opportunities for audit firms to strengthen professional scepticism and effective challenge. These included effectively embedding hybrid working practices. Central to ensuring this is utilising virtual channels for informal as well as formal discussion between audit teams.

Revised standard on auditing group financial statements

44. The FRC has issued revised ISA (UK) 600 on audits of group financial statements. The revised ISA is effective for audits of periods beginning on or after 15 December 2023 (i.e. 2024/25 audits of public bodies), but early adoption is permitted.

Scope

45. The revised ISA (UK) 600:

- expands on the application of other relevant standards to an audit of group financial statements (a group audit)
- deals with special considerations that apply to a group audit, including those circumstances when component auditors are involved.

46. Group financial statements include the financial information of more than one entity or business unit through a consolidation process. This term refers to the:

- preparation of consolidated financial statements
- presentation of combined financial statements
- aggregation of the financial information of entities or business units such as branches or divisions.

47. ISA (UK) 600 (adapted as necessary) may also be useful in an audit of financial statements other than a group audit when the audit team includes individuals from another firm.

Group auditor

The audit team for a group audit comprises:

- the group auditor, which is the group engagement partner and members of the audit team
- component auditors (i.e. an auditor who performs audit work related to a component for purposes of the group audit) where the group auditor determines their involvement.

48. The responsibilities of the group auditor are summarised in the following table:

Area	Responsibility
Audit strategy and group audit plan	Establishing the overall group audit strategy and group audit plan. Determining the involvement of component auditors.
Direction, supervision and review	Directing and supervising component auditors and reviewing their work.
Evaluating conclusions	Evaluating the conclusions drawn from the audit evidence as the basis for forming an opinion on the group financial statements.
Audit evidence	Determining that audit evidence has been obtained to support the conclusions and for the auditor's report on the group financial statements to be issued.

Area	Responsibility
Responding to risks of material misstatement	Determining an appropriate approach to planning and performing audit procedures to respond to the assessed risks of material misstatement in the group financial statements.
Components	Determining the components at which audit work will be performed.

Component auditors

49. Detection risk in a group audit includes the group auditor not detecting that a component auditor has not detected a misstatement that could cause a material misstatement in the group financial statements. Accordingly, paragraph 8 of ISA (UK) 600 requires involvement by the group auditor in the work of component auditors.

50. Paragraph 29 requires the group auditor to communicate with component auditors about their respective responsibilities and the group auditor's expectations.

51. When a component auditor is also performing an audit of the component financial statements, the group auditor may be able to use that audit work. In addition, component auditors may adapt their audit work to also meet the needs of the group auditor. In any event, the requirements of ISA (UK) 600 apply.

Materiality

52. Paragraph 35 requires the group auditor to determine:

- component performance materiality. This is set to reduce aggregation risk to an appropriately low level. Aggregation risk is the probability that the aggregate of misstatements exceeds materiality for the financial statements as a whole. Generally, aggregation risk increases as the number of components increases
- the threshold above which misstatements identified in the component financial information are to be communicated to the group auditor.

Consolidation process

53. Paragraph 38 requires the group auditor to take responsibility for further audit procedures to respond to the risks of material misstatement of the group financial statements arising from the consolidation process. This includes:

- evaluating whether all components have been included in the group financial statements
- evaluating the consolidation adjustments and reclassifications
- evaluating whether management’s judgments made in the consolidation process give rise to indicators of possible management bias

- responding to risks of material misstatement due to fraud arising from the consolidation process.

Communication from component auditors

54. Paragraph 45 requires the group auditor to request the component auditor to communicate relevant matters, including those summarised in the following table:

Area	Matters to be communicated
Financial information	Identification of the financial information on which the component auditor has been requested to perform audit procedures.
Performance of work	Confirmation that the component auditor has performed the work requested.
Laws or regulations	Instances of non-compliance with laws or regulations.
Misstatements	Misstatements identified by the component auditor that are above the threshold.
Fraud	Fraud involving component management or employees who have significant roles in the system of internal control.
Conclusions	The component auditor's overall findings or conclusions.

55. The group auditor is required to:

- evaluate whether communications with the component auditor are adequate for the group auditor's purposes
- determine whether it is necessary to review additional component auditor audit documentation
- determine if any additional audit procedures are to be performed, and by which auditor.

Proposed revisions to international standard on audit evidence

56. The International Auditing and Assurance Standards Board (IAASB) has issued an exposure draft of proposed revisions to ISA 500 on audit evidence. Comments on the proposals in the exposure draft should be submitted through the IAASB website by 24 April 2023.

57. The objectives of the proposed revisions are to:

- clarify the purpose and scope of ISA 500 and explain its relationship with other standards
- develop a principles-based approach to considering and making judgments about information to be used as audit evidence and evaluating whether sufficient appropriate audit evidence has been obtained

- modernize ISA 500 to be adaptable to the current business and audit environment, including the increased use of technology
- emphasize the role of professional scepticism.

58. Some key proposals in the exposure draft are summarised in the following table:

Area	Extant ISA 500	Proposals in exposure draft
Purpose and scope	Extant ISA 500 explains what constitutes audit evidence, and deals with the auditor's responsibility to design and perform audit procedures to obtain sufficient appropriate audit evidence.	The exposure draft retains this principles-based approach and proposes that ISA 500 serve as an overarching standard that deals with the auditor's responsibilities relating to audit evidence when designing and performing audit procedures.
Technology		There are various changes in application material to enable auditors to apply the standard in an evolving audit environment with the increasing use of technology. For example, the application material: • clarifies that the auditor may use manual or automated tools and techniques (paragraph A3) • explains how the use of automated tools and techniques may affect auditor bias, including automation bias (paragraphs A22 and A23) • uses examples that draw attention to the use of technology (2, 5, 6 and 10 in the Appendix).
Definition of audit evidence	ISA 500 defines audit evidence as information used by the auditor in arriving at the conclusions on which the auditor's opinion is based.	The proposed revised definition at paragraph 7(b) reflects that information (input) needs to be subject to audit procedures to become audit evidence (output). The term "information intended to be used as audit evidence" is used to describe the input. Paragraph A34 provides application material that explains the concept of information intended to be used as audit evidence.

Area	Extant ISA 500	Proposals in exposure draft
Sufficiency and appropriateness of audit evidence	ISA 500 refers to the sufficiency (quantity) and appropriateness (quality) of audit evidence.	The exposure draft retains the concepts of appropriateness and sufficiency, but more supporting application material has been added. For example, paragraph A13 explains that the appropriateness of audit evidence is affected by the: • relevance and reliability of information intended to be used as audit evidence • effectiveness of the design of audit procedures applied to the information • auditor's application of those audit procedures.
Persuasiveness of evidence		The exposure draft introduces the concept of persuasiveness. Application material explains the factors that may affect the persuasiveness of audit evidence. Paragraph A9 lists the following factors: • The information intended to be used as audit evidence, including the auditor's consideration of the attributes of relevance and reliability of the information. • Whether the information is from a single source or from multiple sources. • The design and performance of audit procedures, i.e. whether they are appropriate and have been properly applied. • Whether there are inconsistencies between multiple pieces of audit evidence.
Professional scepticism	ISA 500 requires the auditor to design and perform audit procedures that are appropriate in the circumstances	Paragraph 8 of the exposure draft reinforces the exercise of professional scepticism by requiring auditors to design and perform audit procedures in an unbiased manner. Paragraph A20 has been added to explain that this involves not being biased toward obtaining audit evidence that may corroborate the existence of risks of material misstatement or management's assertions, or toward excluding audit evidence that may contradict the existence of risks or such assertions.
Attributes of relevance and reliability		Paragraph 9(b) requires auditors to consider the attributes of relevance and reliability that are applicable in the circumstances. Paragraphs A54 to A62 describe the attributes. For example, paragraph A56 lists the following attributes in considering the degree to which information is reliable:

Area	Extant ISA 500	Proposals in exposure draft
		• The information is free from bias and error; reflects all of the underlying conditions, events, and circumstances; and has not been inappropriately altered. • The source actually generated the information, has the competence and capability to generate the information, and can be trusted. If the accuracy and completeness attributes are applicable, paragraph 10 requires auditors to obtain audit evidence. Paragraphs A63 to A65 explain the circumstances in which the auditor may consider accuracy and completeness to be applicable, and how audit evidence may be obtained.
Management expert	If information has been prepared using the work of a management's expert, the auditor is required, to the extent necessary, having regard to the significance of that expert's work for the auditor's purposes, to: • evaluate the expert's competence, capabilities and objectivity • obtain an understanding of their work • evaluate the appropriateness of the work as audit evidence.	Paragraph 11 of the exposure draft adds a requirement for the auditor to obtain an understanding about how the information prepared by the expert has been used by management in the preparation of the financial statements. The current requirement to evaluate the appropriateness of the expert's work has been removed as it was deemed redundant. The current conditionality requirement ("to the extent necessary, having regard to the significance of that expert's work for the auditor's purposes") was considered unnecessary and has been deleted from the exposure draft.
Stand back		Paragraph 13 introduces a new "stand back" requirement for the auditor to evaluate whether sufficient appropriate audit evidence has been obtained. The 'stand back' requirement also emphasizes the exercise of professional scepticism by requiring the auditor to consider all audit evidence obtained.

Quality reviews of local audits in England

59. The FRC has issued a report that sets out findings from the 2021/22 audit quality inspections of major local audits in England (which include the larger health and local government bodies).

60. The following table provides a summary of the key areas where the FRC considers that improvements in audit quality are required, and which potentially have relevance to public audit in Scotland:

Area	Summary of key findings
Urgently improve financial statements review procedures and the evaluation of identified misstatements	The review identified the following failures to detect material errors in the audited financial statements: • Cash deposits were overstated by £1.7 billion caused by an error in accounts preparation. • Loss on disposal of non-current assets was overstated by £45 million caused by an incorrect audit adjustment. Also, the failure to evaluate the impact of unadjusted audit differences on each line item in the financial statements led to operating expenses being materially misstated.
Ensure there is sufficient justification to support modification of an audit opinion	The audit opinion on the financial statements was modified due to an inability to obtain sufficient appropriate evidence over inventory as a result of the auditor being unable to attend the stock counts. However, alternative procedures were performed over part of the inventory with no issues arising, and the residual balance was not material.
Improve the quality of audit procedures over pension asset valuation	Insufficient evidence was obtained on the valuation of investment assets. The primary substantive procedure was to compare valuations obtained from the custodian to those provided directly by fund managers, but there was insufficient evidence that they were independent. Insufficient evidence was obtained to rely on the valuation controls at fund managers. The service auditor reports were not properly evaluated. There was no evidence that audit procedures were performed to test the accuracy of the return on investments.
Improve the evaluation of assumptions used in investment property valuations	There was insufficient evaluation and challenge of key assumptions used in the valuation of investment property.
Improve the quality of audit procedures over the valuation and classification of financial assets	There was insufficient consideration and challenge of the financial model supporting the valuation and classification of a long-term debtor. There were insufficient procedures on whether financial assets should be classified as short-term investments or cash equivalents.

Area	Summary of key findings
Enhance audit procedures over expenditure	There was no testing of the completeness and accuracy of source data when performing substantive analytical procedures. Weaknesses were identified in the supporting evidence obtained when testing employee benefits, particularly where differences between amounts paid and supporting records were identified. No roll-forward procedures were undertaken when testing the operating effectiveness of controls at an interim date.
Enhance the testing of journal entries	Incorrect date ranges were entered into the firm's journals software when running reports. Journals recorded in the 20-day period after the year end were tested as that was the expected closedown period. The period tested should have been three months to align with the actual closedown period. Journal entries with the characteristics identified by the auditor were not tested for appropriate business rationale or authorisation.
Improve testing performed over business rates	Material debtors and creditors were not appropriately tested. A sufficiently precise expectation was not set when performing substantive analytical procedures over business rates income. Insufficient evaluation of key assumptions was used by the management expert when valuing the provision for appeals.
Audit methodology on going concern	The IAR contained a material uncertainty in relation to going concern, but the assessment focused on financial sustainability rather than the principle of service continuity. Standardised work programmes should be suitably tailored to the sector, including the continued provision of service approach.

61. Examples of good practice identified included the following:

- The audit team's fraud risk assessment demonstrated a good understanding of the sector and financial pressures at the local authority. Owing to the incentive for management to manipulate its reserves position, the audit team identified fraud risks for revenue expenditure funded from capital under statute, minimum revenue provision and the flexible use of capital receipts.
- The audit team appropriately evaluated the competence, capabilities and experience required to audit a highly specialised property. It engaged an auditor's expert to provide support in testing the valuation, which enhanced the team's audit evidence in this higher-risk area.
- The audit team's testing of yields when evaluating assumptions used in investment property valuations included evaluation of the comparators used by management's valuer against third-party market data.

- The audit team demonstrated rigour when challenging the assumptions made in setting the business rates appeals provision, in particular by benchmarking to other local authorities. The audit opinion was ultimately qualified as the auditor was unable to obtain sufficient appropriate audit evidence over the amount of the provision.

- The audit team robustly followed up on errors identified in its additions testing by extending its sample and challenging management to recognise a prior-year adjustment.

- The audit team consulted with an internal panel of senior public sector specialists on the audit procedures performed over a subsidiary whose financial performance had deteriorated in the year. There was clear evidence of challenge by the audit team in areas such as the disclosure of events after the balance sheet date and parent company guarantees.

Guidance on impact on ISAs of IAS 1 amendment

62. The IAASB has issued guidance on the impact on ISAs of an amendment to IAS 1 Presentation of Financial Statements. The amendment requires entities to disclose their material accounting policy information, instead of significant accounting policies. It is effective for reporting periods beginning on or after 1 January 2023, with early application permitted.

63. The guidance advises auditors to evaluate how management has addressed the effect of the amendments to IAS 1 on the entity's disclosures about accounting policies. This includes understanding the effect of these amendments on the entity's financial reporting processes.

64. Various ISAs contain requirements that are relevant to the auditor's work on disclosures in the financial statements. The guidance clarifies that the amendments to IAS 1 do not impact the principles-based requirements of the ISAs.

65. However, relevant references in the IAR to significant accounting policies will need to be revised to material accounting policy information. Professional Support will revise the model forms of IAR in all sectors from 2023/24 to refer to material accounting policy information.

Report on net zero disclosures

66. The FRC has issued a report on the disclosures entities should make on net zero or other greenhouse gas reduction commitments. The report focuses on three elements that the FRC considers that users want to understand from net zero disclosures.

67. Each element is explained in the following table, along with disclosures to be considered at both a basic and advanced level:

Level	Commitments	Impacts	Performance
	Level of ambition, and scope, nature and timing of the commitment	**How the commitment impacts strategy, business model, assumptions, uncertainties, risks and opportunities**	**How performance is being measured and high-quality data ensured, and the actions management is taking**
Foundational - providing a basic understanding of the commitment, including high-level targets, timelines and impacts	Types of greenhouse gases included Scopes of emissions included Type of reductions committed to Timelines for commitment Extent and nature of planned offsets Information on any exclusions or limitations to the commitment	Strategy for achieving net zero Risks and opportunities of the commitment framed to the business in a balanced way Estimates of potential future costs Explanation of uncertainties and assumptions in a manner consistent with financial statements	Frameworks and methodologies for setting targets and measuring progress Targets set Progress to date, and whether in line with expectations An understanding of the expected trajectory Explanation of relevant metrics
Advanced - providing updates on progress, refinements of goals, and more detailed information on impact and accountability	Consideration of whether the commitment will be updated, for example, a new approach or a more ambitious target	Updated views on impact and financing requirements Transition plans Quantitative estimates or additional scenario analysis helpful for users	Information on leading performance indicators Consideration of whether any external assurance would be appropriate

68. The report explains that effective processes and governance underpin commitments and plans, and lead to better disclosures. Robust systems and controls will enable entities to better understand their progress, and achieve their net-zero commitments over the longer term. The report sets out four stages summarised in the following table:

Define the commitment	Assess the impact	Measure progress	Refine the approach
What will be reduced and over what time period?	How will the business model and strategy need to change?	What internal targets and measures need to be in place?	What lessons have been learned to date?
What operation can be reduced, and what offsets can be used?	What resources are needed? What gaps are there?	Are the systems, controls and processes in place to measure and monitor progress?	Are there areas that could be improved on?
What interim targets need to be set?	What new policies need to be put in place on business travel or new supplier relationships?	Is there access to sufficient data?	Do any commitments need to be redefined?
How will goals be communicated internally?	How will the commitment embed into decision making?	What internal review processes are needed?	Is any external review needed?
	How much will it cost?	How do measures link to individual objectives?	How will lessons be shared with the wider workforce?

Report on a good annual report and accounts

69. The FRC has issued a report that sets out the attributes of a good annual report and accounts (ARA). In setting out these attributes, the FRC use a principles-based framework that identifies corporate reporting principles and effective communication characteristics. The report also provides examples to illustrate the underlying principles.

70. An assumption that underpins the report is that a good ARA must comply with the relevant legal, regulatory, financial reporting and code requirements. However, preparing a high-quality ARA is more than just a compliance exercise.

Materiality

71. Materiality is the bedrock of corporate reporting. It is the primary tool that helps entities to focus on key matters. Materiality informs the breadth and depth of what needs to be included in the ARA.

72. Materiality applies to all transactions, balances and disclosures (numerical and textual) in the ARA, not just those transactions affecting the financial statements. What is material in any part of the ARA will be determined by quantitative and qualitative factors as well as their nature or context.

73. A transaction, balance or disclosure would be considered quantitatively material if the size of its impact is likely to influence users' decisions or their perception of the entity's performance or future prospects. Determining whether something is quantitatively material is a matter of judgement, but the benchmark used should be the most appropriate in the context of the business and of greatest value and interest to the users.

74. Where auditor materiality is disclosed in the auditor's report, users are likely to assume that the entity has used a similar quantitative materiality in their approach to the preparation of the financial statements. When this is not the case, the entity may wish to disclose details of their assessment.

75. Qualitative factors are those factors other than size. Determining whether something is material as a result of a qualitative factor is also a matter of judgement.

Corporate reporting principles

76. Corporate reporting principles are the overarching qualitative characteristics of a good ARA. They are summarised in the following table:

Characteristics	Guidance
Accuracy	An accurate ARA is free from material misstatement and error. Accuracy depends on the quality of the underlying data supporting both financial and non-financial information. Appropriate disclosure is vital to explain estimation uncertainty which usually requires quantification of the key assumptions and a sensitivity analysis. Entities are encouraged to disclose the sources of significant facts and claims made in narrative reporting. Language used in narrative reporting needs to be specific, not open to misinterpretation by users, and balanced.
Connected and Consistent	An ARA is connected when information on related subject matter is linked together so that users can understand how the elements interact. ARAs should be consistent both internally and with other public information produced by the entity. Narrative reports should discuss the material transactions and balances reported elsewhere in the ARA. Information in narrative reports should be consistent with the information presented in the financial statements.
Complete	Completeness reflects the breadth, rather than depth, of information. Achieving completeness is not a tick box exercise and materiality should be applied to determine what must be disclosed. An ARA should include all the positive and negative material information needed by a user to understand the financial performance and position, development, and future prospects.
On-time	Although the FRC encourages entities not to compromise quality by compressing reporting timetables, long lead times between the balance sheet date and the date of publication reduce the usefulness of the ARA.

Characteristics	Guidance
Unbiased	Information is unbiased if it is balanced. A balanced ARA should refer to both positive and negative aspects of performance, position and future prospects as well as the risks and opportunities the entity faces. The ARA as a whole should present an open and honest account of the entity's activities and performance and future prospects.
Navigable	ARAs on websites should be navigable which means they should include detailed contents pages, navigation panes, clear titles and descriptions, specific cross references and hyperlinked cross references. They should also be searchable to enable users to perform text searches for specific words and phrases.
Transparent	Any significant judgements should be disclosed. Additional disclosures over and above stated requirements may be necessary for users to fully understand certain transactions. Audited and unaudited information should be clearly labelled.

Effective communication principles

77. Communication principles focus on how information should be delivered to users. They are summarised in the following table:

Characteristics	Guidance
Company-specific	An ARA should provide insights into decision making, and explain the business model in jargon-free language. Key judgements and estimates should be explained with details of how the figures would change if they were altered. Entities should replace boilerplate disclosure with information that is tailored to their specific circumstances.
Clear, concise and understandable	A clear, concise and understandable ARA: • uses straightforward language and short sentences • uses specialist terms only where necessary and makes sure they are used consistently • focuses on content that is important to stakeholders • excludes irrelevant information • does not repeat information clearly shown in diagrams, tables or other narrative • defines specialist terms and acronyms in a glossary • uses diagrams, images and tables only if it makes the information easier to understand.

Characteristics	Guidance
Clutter free and relevant	Irrelevant material obscures the important information that users need to make informed decisions and judgements. If rolling forward last year's publication, preparers should: • review the draft carefully and remove information that is no longer relevant • include relevant disclosures required by amended requirements or new circumstances.
Comparable	A comparable ARA contains metrics that are calculated consistently year on year, clearly defined, and reconciled to GAAP measures. If there has been a significant change to the calculation of a metric, the entity should: • describe the change • explain why it results in more reliable and relevant information • restate the comparatives.

Report on corporate reporting 2021/22

78. The FRC has issued a report on the outcomes of reviews of the corporate reporting of companies in the year to 31 March 2022. This report sets out the FRC's view of:

- the current state of corporate reporting in the UK
- the elements of better-quality reporting
- shortcomings that require improvement.

79. Cash flow statements is highlighted in the report as an area of considerable concern. The report advises entities to ensure that

- reported cash flows are consistent with amounts reported elsewhere in the annual report and accounts
- non-cash items are excluded from the statement and adjustments for material non-cash transactions are disclosed
- classification of cash flows, cash and cash equivalents comply with relevant definitions and criteria in the standard
- cash flows are not inappropriately netted.

80. The report also explains the FRC's expectations for 2022/23 accounts. These are shaped by their findings, as well as developments in reporting requirements and the business environment. Expectations that also apply in the public sector are summarised in the following table:

Area	Expectation
Risks	Unambiguous description in the narrative reporting of risks facing the entity, their impact on strategy, business model, cross-referenced to relevant detail in the reports and accounts.
Impact of climate change	Specific, balanced and well-integrated information about the impact of climate change in narrative reporting, and appropriate reflection of material climate-related commitments, risks and uncertainties in the financial statements.
Impairment	Impairment disclosures that assign values to, and explain how, the key assumptions used have been determined.
Judgements and estimates	Clear disclosure of significant judgements and key assumptions underlying major sources of estimation uncertainty, including information about the sensitivity of reported amounts.
Financial instruments	Transparent disclosure of the nature and extent of material risks arising from financial instruments, including significant assumptions made in the measurement of expected credit losses.
Objectives of accounting standards	Specific information that meets the disclosure objectives of the relevant accounting standards and not just the specific disclosure requirements. Additional information (beyond the standards' requirements) should be included where needed to understand the impact of particular transactions, events or circumstances.
Inflation	Clear explanation of the nature of significant inflationary features in revenue, supply, leasing and other financing contracts, and their effect on the financial statements.
Materiality	Clear, concise and understandable disclosure that omits immaterial information.

7: Fraud and irregularities

Contact: Anne Cairns, acairns@audit-scotland.gov.uk

This chapter contains a summary of fraud cases and other irregularities facilitated by weaknesses in internal control at audited bodies that have recently been reported by auditors to Professional Support.

Auditors should consider whether weaknesses in internal control which facilitated each fraud may exist in their audited bodies and take the appropriate action.

Expenditure

School funds

81. A head teacher embezzled over £5,300 from a school fund.

Key features

The teacher fraudulently used the school fund purchase card, which was held in the name of another member of staff, for personal purchases. The teacher also falsified an invoice to disguise the payment of a personal membership fee, and misappropriated school fund concert cash that had been entrusted to the teacher.

The fraud was identified after concerns were raised regarding misappropriation of the school fund purchase card.

Subsequent investigations identified that high value items purchased from the school fund could not be located on the school premises. These items were subsequently recovered from the teacher's home.

The fraud was possible as due to the seniority of the teacher; the actions were not challenged by other staff. In practice, there was no segregation of duties.

The council has:

- revised school fund procedures
- introduced random sampling of purchase card transactions
- provided fraud awareness and procurement training to school staff.

The case has been reported to the Procurator Fiscal. The teacher resigned following the instigation of disciplinary proceedings.

Items to the value of £1,600 have been recovered.

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Technical Bulletin 2022/4

Technical developments and emerging risks from October to December 2022

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AUDIT SCOTLAND

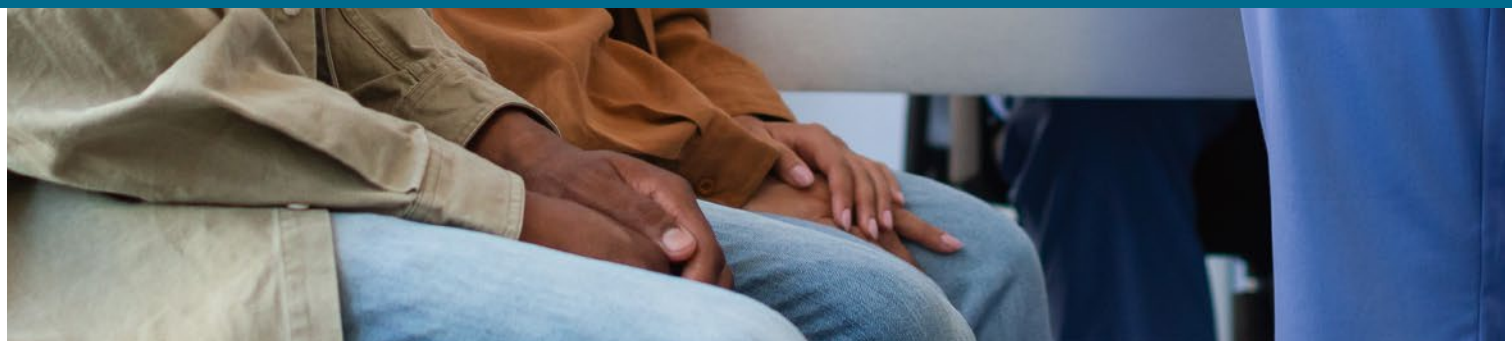
Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

AS.4.0

NHS in Scotland 2022

AUDITOR GENERAL

Prepared by Audit Scotland
February 2023



Contents

Key messages

Growing financial pressures present a real risk to the investment needed to recover and reform NHS services

The general trend of health spending in Scotland is one of growth. Despite this, the NHS in Scotland faces significant and growing financial pressures. These include inflation; recurring pay pressures; ongoing Covid-19 related costs; rising energy costs; a growing capital maintenance backlog; and the need to fund the proposed National Care Service. These pressures are making a financial position that was already difficult and has been exacerbated by the Covid-19 pandemic, even more challenging. This could limit investment in recovery and reform.

It is difficult to accurately measure the progress of the Scottish Government's NHS Recovery Plan

Financial pressures, workforce shortages, pressures on the social care system and the ongoing impact of Covid-19 are making progress extremely difficult. The plan commits £1.26 billion of funding to help reduce the healthcare backlog and redesign services, and sits alongside a range of other initiatives that support reform. But it is a high-level, top-down document and does not contain the detailed actions that would allow overall progress to be accurately measured. Meanwhile, the backlog of care that built up during the pandemic continues to grow. More people are being added to waiting lists than are being removed from them, and people are waiting longer for treatment. There have been delays in opening three new National Treatment Centres - a key element in increasing activity levels in planned care. Delays in getting social care support for patients who are ready to leave hospital continue to limit the availability of beds.

Workforce capacity remains the biggest risk to the recovery of NHS services

Some progress has been made against the recruitment targets set out in the NHS Recovery Plan, but boards are finding it challenging to grow their workforce numbers to the required level. The NHS workforce remains under severe pressure and there are concerns over staffing levels, wellbeing and retention. These workforce issues predate the pandemic. But the NHS Recovery Plan was not informed by robust modelling and there is a risk workforce targets will not be achieved. The NHS continues to experience high vacancy and turnover rates, higher than usual sickness absence and gaps in the workforce.

The Scottish Government needs to be fully transparent on recovery progress and how long people will have to wait for treatment

The challenges facing the NHS in Scotland are unprecedented. The Scottish Government will have to make difficult choices and prioritise which ambitions it can deliver against. It needs to be more transparent about what progress is or is not being achieved. Information on expected waiting times for treatment must be clear and meaningful. This will allow the Scottish Government to better manage the public's expectations about what can be delivered with the resources available. There are early signs that the Scottish Government is working to drive forward innovation and reform. It is essential that this work progresses at pace, for the sustainability of health and care services and to continue improving people's lives.

Recommendations

The Scottish Government should:

- publish a revised medium-term financial framework (MTFF) for health and social care that clearly aligns with the medium-term financial strategy (MTFS) for the entire Scottish Government, as soon as possible after the next MTFS is published, to determine what financial resources will be available and to give a clear understanding of potential financial scenarios (paragraph 18).

- as soon as possible, complete work on modelling demand and capacity in the NHS in Scotland to inform planning for future service delivery, taking into consideration demographic change, service redesign options and anticipated workforce capacity (paragraph 75).

- revisit its NHS Recovery Plan commitments annually and use its annual progress updates to report clearly and transparently on what progress has been made and whether those commitments, or the targets and delivery timeframes related to them, need to change and why (paragraph 86).

- ensure that targets for tackling the backlog of care are clear, publish accessible and meaningful information about how long people will have to wait for treatment, and urgently explore all options to provide support to the most vulnerable people waiting for treatment to minimise the negative impact on their health and wellbeing (paragraphs 71, 101 and 106).

- publish annual progress updates on the reform of services, showing the effectiveness and value for money of new innovations and ways of delivering NHS services (paragraph 136 to 138).

The Scottish Government and NHS boards should:

- work with partners in the social care sector to progress a long-term, sustainable solution for reducing delayed discharges from hospital (paragraph 39).

- ensure focus on staff retention measures is maintained, including wellbeing support, and continually look at ways to increase the impact of these measures (paragraph 50).

- work together more collaboratively on boards' delivery, financial and workforce plans to maximise boards' potential to achieve the ambitions in the NHS Recovery Plan, by balancing national and local priorities against available resources and capacity and setting realistic expectations for the public (paragraph 78).

- urgently implement a programme of engagement with the public to enable an open discussion about the challenges facing the health sector in Scotland and help inform future priorities and how the delivery of services will change (paragraph 139).

Introduction

1. In our NHS in Scotland 2020 and NHS in Scotland 2021 reports we examined how the Scottish Government and NHS boards had responded to the Covid-19 pandemic. We also considered the impact of the pandemic on how NHS services were delivered, and on the financial position of the NHS in Scotland.

2. The Covid-19 pandemic continues to affect the delivery of NHS services. A huge backlog of people waiting for healthcare has built up since the pandemic began, as planned care was paused for a while, and activity levels are not yet fully back to pre-pandemic levels. Scotland's healthcare system remains under severe pressure, operationally and financially.

3. Scotland's NHS is not alone in facing these issues. Across the globe, healthcare systems face similar pressures. Many of the factors contributing to the extremely difficult situation facing the NHS in Scotland are not specific to health services, and many are not within the control of the Scottish Government or NHS boards. But it is crucial that both the Scottish Government and NHS boards are realistic in their ambitions and are clear about what has been and can be achieved.

4. The Scottish Government has begun efforts to help NHS services recover from the impact of the Covid-19 pandemic. It published its NHS Recovery Plan 2021-2026 in August 2021. This outlined the ambitions for recovering health services to better than pre-pandemic levels and clearing the backlog of care. This follows previous measures to progress recovery from Covid-19. In our 2021 briefing on the Covid 19: Vaccination programme we reported on the Scottish Government's successful implementation of the vaccination programme.

5. The NHS Recovery Plan is ambitious. Our NHS in Scotland 2021 report identified several risks to its successful implementation. In this report we:

- take a further look at those risks and comment on progress against relevant recommendations from our NHS in Scotland 2021 report
- consider the financial and operational pressures facing the NHS in Scotland and what that means for progress against the Scottish Government's recovery ambitions
- assess progress in the first year of implementation of the Recovery Plan.

6. Our audit methodology is set out in Appendix 1. We plan to carry out separate performance audits of adult mental health services and drug-related deaths and, therefore, do not go into detail on these issues in this report.

7. NHS boards are largely responsible for implementing the actions set out in the NHS Recovery Plan. To better understand how the plan affects NHS boards and whether they are likely to achieve the ambitions set out within it, we conducted case studies of three contrasting boards. They are NHS Ayrshire and Arran, NHS Highland and NHS Lothian. Throughout the report we refer to evidence gathered from these NHS boards to provide insight from a local perspective on the NHS Recovery Plan.

The NHS in Scotland faces unprecedented challenges

Delivering on the Scottish Government's recovery ambitions for the NHS will be extremely difficult due to financial and operational pressures

8. Before assessing progress in the first year of the Scottish Government's NHS Recovery Plan 2021-2026, it is important to provide context on the challenges facing the system. Across the world, healthcare systems are under extreme pressure. Global and local factors are creating very difficult operating conditions for the NHS in Scotland.

9. In previous reports we outlined how the NHS in Scotland was not being run in a financially or operationally sustainable way, even before the Covid-19 pandemic. Our NHS in Scotland 2019 report highlighted the need for reform in the NHS to ensure services are sustainable. Reform would mean changes to the way health services are delivered, to improve efficiency, effectiveness and value for money. It should lead to high quality services being delivered within the resources available.

10. Factors such as Scotland's ageing population, growing demand and rising costs meant the system was already under pressure. This situation has been exacerbated by the Covid-19 pandemic, rising inflation and the cost-of-living crisis. The Scottish Government faces significant challenges in recovering services and delivering reform.

The response to Covid-19 and a range of emerging financial pressures have exacerbated the financial position of the NHS in Scotland

11. The Covid-19 pandemic brought substantial additional cost pressures for the NHS in Scotland. We highlighted the additional Covid-19 related funding allocated across Scotland's health sector in our NHS in Scotland 2020 and NHS in Scotland 2021 reports. In 2020/21, £2.9 billion of additional Covid-19 related funding was allocated across health and social care in Scotland. This fell to £2.6 billion in 2021/22.

12. This additional funding came from the UK Government in the form of Barnett consequentials.[1] In our report on Scotland's financial response to Covid-19 we point out that the UK and Scottish budgets for 2022/23 do not include any specific Covid 19 funding. There will be no further Barnett consequentials for Covid-19 related spend, but Covid-19 related costs will remain, such as the cost of vaccinations. These costs must now be met from the Scottish Government's existing health and social care budget.

13. The Scottish Government is taking steps to reduce Covid-19 costs in core areas, such as personal protective equipment (PPE), vaccinations, and Test and Protect, through its Covid Costs Improvement Programme (CCIP). It is working with NHS boards to forecast their costs, identify savings and deliver services in a more sustainable way. The Scottish Government has given each NHS board a Covid-19 funding budget for 2022/23 and instructed them to keep Covid-19 costs within it.

14. Each of our case study boards initially predicted that their actual Covid-19 costs would be higher than the amount in their budgets, but are working hard to bring costs in line. NHS Lothian now predicts that it will stay within its Covid-19 budget this year but will have a recurring funding gap next year when Covid-19 funding is further reduced. Total Covid-19 related spend in 2022/23 across the Scottish Government health and social care directorate, NHS boards, and Health and Social Care Partnerships (HSCPs) is currently expected to be around £723 million.

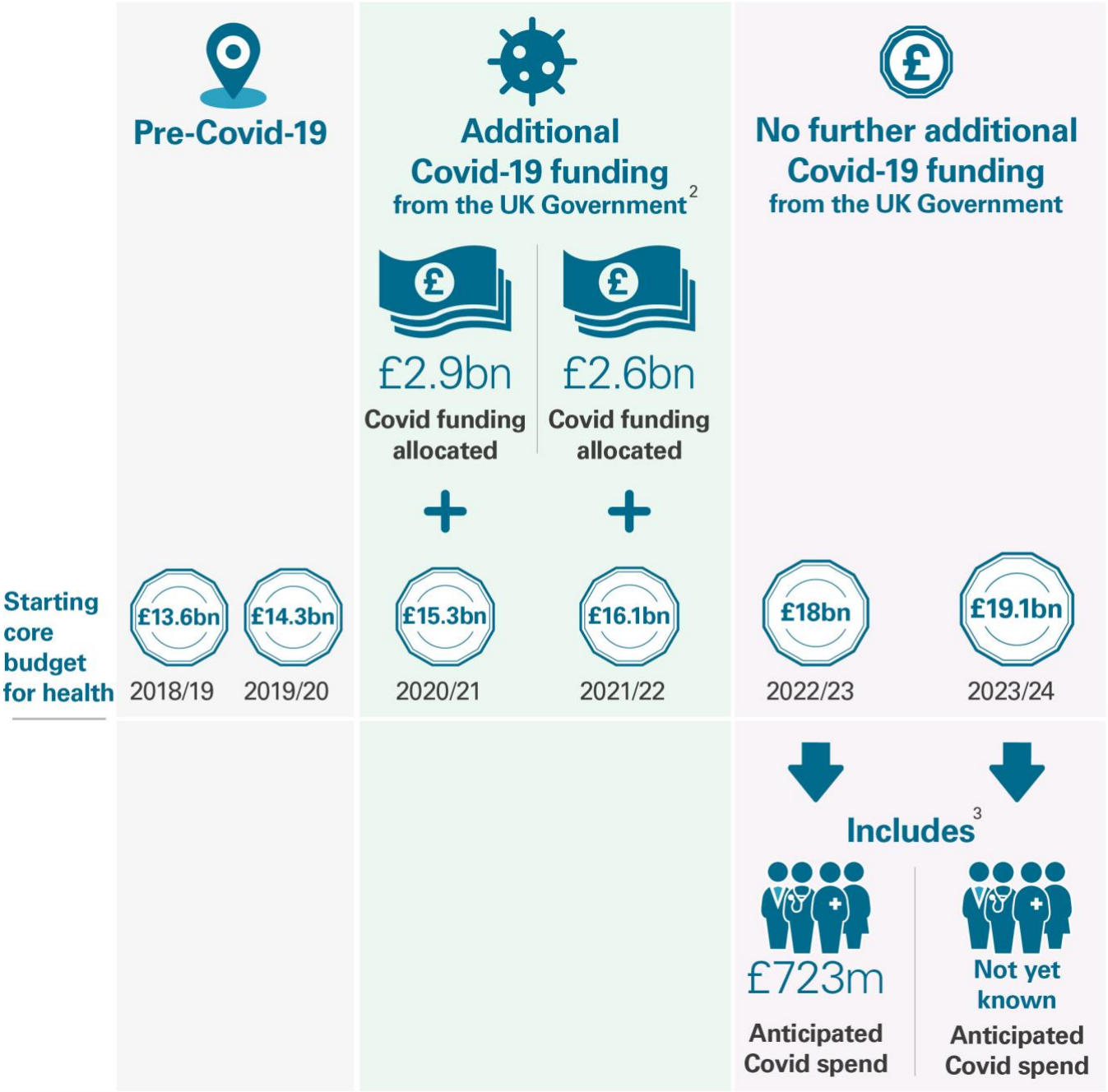
15. We have previously set out the need for transparency over Covid-19 spending, but also the difficulty in defining what is Covid-19 spending in our Scotland's financial response to Covid-19 report. Moving forward, the Scottish Government's health and social care directorate will not monitor Covid-19 related costs separately, particularly as there is no longer a separate Covid-19 funding stream.

16. As Exhibit 1 (page 11) shows, the Scottish Government's health budget has increased by £4.4 billion since 2018/19. The UK Government provided significant additional funding for Covid-19 related spend in 2020/21 and 2021/22, but remaining Covid-19 related costs must be met from the Scottish Government's core health and social care budget from 2022/23 onwards. The general trend in health spending in Scotland is one of growth. In the Scottish Budget: 2023-24 the total allocation for health and social care is £19.1 billion.[2] This increase is earlier than anticipated, with the Scottish Government having previously committed to increasing its health and social care budget to £19 billion by 2026/27.[3]

17. The financial position of the NHS in Scotland is concerning. As well as Covid-19 related costs, a range of additional financial pressures (outlined below) have grown or emerged in recent years. Our three case study boards all confirmed these pressures will impact on their financial sustainability.

18. The Scottish Government also recognises the challenges these pressures bring to the NHS in Scotland. Recent economic instability, in the UK and internationally, has made it difficult to predict its income and expenditure. The Scottish Government is working on its revised medium-term financial framework (MTFF) for health and social care. It should ensure this aligns with its medium-term financial strategy (MTFS) for the entire Scottish Government and publish the MTFF for health and social care as soon as possible after the MTFS is published in May 2023.

Exhibit 1.
Health funding in Scotland 2018/19 to 2023/24[1]



Notes:
1. These figures do not take into account inflation.
2. Additional Covid-19 funding from UK Government via Barnett consequentials.
3. Covid-19 related expenditure met from the existing Scottish Government health and social care budget. No additional funding was provided by the UK Government.

Source: Scottish Government

UK inflation has increased substantially in the last two years

19. Inflation in the UK has reached levels that are unprecedented in recent times, reaching 10.5 per cent in December 2022.[4] This is up from 5.4 per cent in December 2021 and from 0.6 per cent in December 2020. NHS services are not immune to inflation and the NHS will face rising costs for everything from food to medicines. Prices are much higher than they were before the Covid-19 pandemic, when the NHS already faced significant financial challenges. The NHS, with a high number of large buildings that need heat and energy, is badly affected by the large increase in energy costs in 2022.

20. A new pay offer for NHS staff remains unresolved, adding to financial uncertainty. The cost-of-living crisis has created strong demand for pay increases from workers across the public sector. The Scottish Government made an average pay increase offer of 7.5 per cent for NHS staff in November 2022. This equates to a £515 million commitment. The Unison and Unite trade unions have accepted this offer. But it has been rejected by the GMB union, the Royal College of Nursing and the Royal College of Midwives, and the threat of industrial action cannot be ruled out. The Scottish Government must meet this commitment from its existing budget.

The NHS capital maintenance backlog is likely to have increased

21. We last reported on the NHS capital maintenance backlog in our NHS in Scotland 2020 report. At that time the figure stood at £1.03 billion. The Scottish Government plans to double investment in capital backlog maintenance over the next five years. But it will have to balance capital investment with the other financial pressures it faces. Any reduction in the planned capital investment will mean that the Scottish Government will have to prioritise which projects will go ahead. This could affect progress in recovering services and increasing capacity, and therefore have a negative impact on patients.

The proposed National Care Service will place a huge strain on the health and social care budget

22. The Scottish Government introduced the National Care Service (Scotland) Bill in June 2022. The Scottish Parliament Information Centre (SPICe) published a briefing on the National Care Service Bill in October 2022.[5] According to SPICe's analysis of the Bill's Financial Memorandum, the estimated costs of implementing the Bill in the period 2022/23 to 2026/27 are between £644 million and £1.26 billion.

23. These amounts cover the direct costs of implementing the legislation and do not include costs associated with any policy decisions that may accompany the Bill, for example pay increases for social care staff or investment in digital and data solutions. As a result, the overall cost of implementing the legislation and supporting it with necessary policy decisions could be much higher than those estimates. This represents a significant unknown financial commitment to be met from the Scottish Government's health and social care budget. The Scottish Government has committed to spending an additional £840 million on social care, an increase of 25 per cent, by 2026/27.[6]

NHS boards predict an extremely challenging financial position

24. Analysis of NHS boards' 2022/23 financial plans shows that of the 14 territorial boards, only three are predicting to break even in 2022/23 if their savings targets are met. Seven of the eight national NHS boards are predicting to break even in 2022/23 if their savings targets are met. In total, boards need to make £620.6 million of savings to break even in 2022/23 (Appendix 2).

25. In 2020/21 and 2021/22 the Scottish Government provided non-repayable financial support to ensure all NHS boards delivered financial balance due to the exceptional financial challenges brought about by the Covid-19 pandemic. This arrangement stopped at the end of 2021/22 with boards again expected to operate within one per cent of their total core revenue funding. This is a return to a commitment agreed as part of the MTFF in 2018.

26. NHS boards have returned to medium-term financial planning and have prepared three-year financial plans covering the period 2022/23 to 2024/25. The one per cent flexibility is contingent on NHS boards producing a credible financial plan and repayment of this flexibility in the three-year period. Common concerns identified in the financial plans of our three case study boards include:

- predicted growing levels of deficit in the medium-term
- difficulty reducing continuing Covid-19 costs
- uncertainty around funding pay increases for staff.

27. Territorial boards' planned efficiency savings are not enough to close the predicted financial gap in 2022/23. The Scottish Government has brought back financial support, known as brokerage, for boards predicting a financial deficit. The Scottish Government will discuss repayment options with individual NHS boards following the development of a credible financial plan.

28. Our November 2022 briefing, Scotland's public finances: Challenges and risks, highlighted that the Scottish Government has limited room for manoeuvre to make changes to balance the 2022/23 budget and is facing difficult choices setting the 2023/24 budget. A balance must be struck between short-term necessities and longer-term priorities, and the Scottish Government will need to revisit its priorities if the economic and fiscal conditions worsen. Faster reform is needed to protect public services in the long term and improve people's lives.

The healthcare system remains under extreme pressure

29. As well as financial pressures, there are several other factors contributing to an increasingly difficult operating environment. Workforce shortages and pressures on the social care system are affecting the flow of patients through hospitals. The impact of these pressures can be seen across the healthcare system, in increased Accident & Emergency (A&E) waiting times, longer ambulance turn-around times and the growing number of delayed discharges. The NHS in Scotland also faced severe winter pressures in 2022/23.

Performance against the A&E waiting times target is considerably below target

30. Ninety-five per cent of people attending A&E should be seen and admitted, discharged, or transferred within four hours. This target has not been hit since July 2020, and performance declined further in 2022. In August 2021, performance fell below 80 per cent and has remained there since. In December 2022, performance on this measure fell to 62.1 per cent. The number of people experiencing an extremely long wait (more than eight, or more than 12 hours) increased in 2022.[7]

Pressure has increased on remote services

31. The NHS in Scotland has introduced new ways for people to access health services remotely. NHS 24 provides health information and advice through its 111 telephone service and via the NHS Inform website. These services identify the most appropriate way for people to access services and help to reduce the number of people attending GP practices and A&E in person.

32. The use of these services has increased as pressure has grown on wider health services. December 2022 saw a higher than usual number of calls to NHS 24 and a high volume of traffic to the NHS Inform website (Exhibit 2, page 16).[8] NHS 24 is progressing with the planned recruitment of 200 new staff by March 2023 to help cope with increasing demand on its services.

33. Patients who call NHS 24 may be referred to a Flow Navigation Centre (FNC). FNCs, introduced as part of the Redesign of Urgent Care (RUC) programme, are now in place in each NHS board to help identify the best pathway of care for patients within their community. Other services, such as the Scottish Ambulance Service, GPs, or pharmacies, can also access FNCs.

The Scottish Ambulance Service is losing staff time due to increased turnaround times at hospitals and increased time at the scene of calls

34. The Scottish Ambulance Service (SAS) is experiencing long waits when it arrives at A&E departments with patients. Hospital turnaround times have increased due to the lack of available beds in hospitals. SAS is also spending more time at the scene of calls, as patients often have more complex needs compared to before the Covid-19 pandemic. Over the winter, the number of emergency incidents dealt with by SAS increased substantially, reaching more than 16,000 in the last week of December 2022. This was 11 per cent higher than the average of the previous four weeks.[9]

35. SAS has successfully recruited 458 new staff to increase its capacity. It has also implemented a range of measures to manage demand and reduce the number of people attending A&E. It introduced an Integrated Clinical Hub to support patients with urgent rather than emergency care needs (Case study, page 15). SAS is working with NHS boards to optimise their flow navigation arrangements.

Case study

The Scottish Ambulance Service introduced an Integrated Clinical Hub to support patients with urgent care needs

In 2022, SAS introduced an Integrated Clinical Hub, with the aim of supporting patients with urgent, rather than emergency, care needs. The hub brings together senior clinicians, such as GPs, Advanced Nurse and Paramedic Practitioners, and Paramedic Clinical Advisors. Many patients with urgent care needs can benefit from a detailed conversation with a senior clinician to identify the best treatment pathway for them. That could be an ambulance, referral to another part of the urgent care system, or self-care advice.

This means patients are directed towards the most appropriate part of the service for their needs and receive support and reassurance. Patients with the most acute or urgent needs are identified and prioritised. It also helps to make sure resources are used more efficiently throughout the healthcare system.

SAS Advanced Practice Clinicians consult with up to 15 per cent of 999 demand, with 50 per cent of these calls not requiring a 999 ambulance. This avoids over 100 ambulance dispatches per day with patients being directed to more appropriate sources of support for their needs.

Source: Scottish Ambulance Service

Delayed discharges remain a barrier to patient flow through hospitals

36. Delayed discharge occurs when a patient is clinically ready to leave hospital but continues to occupy a hospital bed. This is usually because the support necessary to allow a patient to leave hospital is not in place. In our Social care briefing, from January 2022, we highlighted pressures on the social care system and on social care funding. These pressures are making it difficult to find appropriate care packages for patients ready to leave hospital. This is causing an increase in delayed discharges, resulting in fewer beds becoming available for new patients entering the system. In early January 2023, the Scottish Government reported that hospital bed occupancy across Scotland was above 95 per cent.[10]

37. Our NHS in Scotland 2021 report highlighted how the Scottish Government's rapid discharge strategy resulted in a substantial drop in delayed discharges in the early stages of the Covid-19 pandemic. But delayed discharges reached pre-pandemic levels again by September 2021, and in 2021/22 the annual average length of stay in hospital increased to the highest level since 2014/15 (provisional figures).[11] In December 2022, the average number of beds occupied each day by patients whose discharge was delayed was 1,878 (23.4 per cent higher than in December 2021).[12]

38. In early January 2023, the Scottish Government announced £8 million of funding to purchase 300 interim beds in care homes, paying 25 per cent above the national care home contract rate.[13] This is in addition to 600 interim care home beds already in operation. The additional care home beds are intended to

provide transitional care to patients awaiting social care support, and to provide some temporary assistance in reducing the number of people occupying hospital beds who are clinically ready to leave hospital.

39. We recommended in our NHS in Scotland 2021 report that the Scottish Government and NHS boards should work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital. The Scottish Government and NHS boards have progressed several measures aimed at reducing delayed discharges. These include measures to increase the number of patients that can be seen remotely, which have been successful in saving hospital bed days. They also include improving discharge planning arrangements and additional investment in social and community care. Despite these measures, the number of delayed discharges continues to grow. The Scottish Government and NHS boards should continue to seek a sustainable, long-term solution, working jointly with partners in the social care sector.

Exhibit 2.
The healthcare system remains under extreme pressure

	Dec 2019	Dec 2020	Dec 2021	Dec 2022
Percentage of A&E attendances seen within 4 hours	83.8%	86.3%	75.7%	62.1%
Average number of beds occupied each day due to delayed discharges	1,465	1,076	1,522	1,878
Number of people in hospital with Covid-19 (7-day average at end of Dec)	-	1,190	833	1,267
Number of calls made to NHS 24 111 service	-	-	182,200	217,989
NHS Inform website page views (core service, excludes Covid-19)	-	-	10.7m	12.4m

Source: Public Health Scotland and NHS 24

Covid-19 and other respiratory viruses continue to put pressure on health services

40. New waves of Covid-19 have affected hospital capacity and staff availability, sometimes leading to further temporary pauses or reductions in services. Although NHS Scotland was officially stood down from an emergency footing in April 2022, the pandemic and its impact on health services is ongoing.

41. The number of patients in hospital with Covid-19 is still putting pressure on the NHS in Scotland. These patients require isolation from other patients for infection control purposes and this has an impact on hospital capacity. In 2022, the number of patients in hospital with Covid-19 peaked in April, but smaller peaks followed in July and October. Towards the end of the year the average number of people in hospital with Covid-19 began to rise again rapidly. In the last week of December 2022 there were, on average, 1,267 patients in hospital with Covid-19.[14]

42. Scotland experienced extraordinary levels of winter flu at the end of 2022. There was also an outbreak of Strep A infections and an increase in other respiratory viruses at this time. This further increased pressure and demand on health services. NHS Borders and NHS Greater Glasgow and Clyde paused routine non-urgent elective procedures due to the pressures faced in the NHS system in January. NHS Ayrshire and Arran paused inpatient planned care.[15] The majority of other boards also reported daily cancellations due to staffing and bed pressures at this time.

The NHS workforce remains under severe pressure and there are concerns over staff capacity, wellbeing and retention

43. The Scottish Government introduced a new National Workforce Strategy for Health and Social Care (2022) to address the significant pressures facing the NHS workforce.[16] The workforce remains under severe pressure. High staff turnover rates, higher than normal sickness and vacancy rates, and gaps in the workforce continue to have an adverse effect on workforce capacity.

44. Although the number of NHS staff is at a record high, the staff turnover rate has increased (Exhibit 3, page 18). The vacancy rate for Allied Health Professionals (AHPs) has increased from 3.9 per cent in March 2017 to 8.7 per cent in September 2022. The vacancy rate for nursing and midwifery has increased from 4.5 per cent to 9 per cent over the same period. The sickness absence rate for NHS Scotland in 2021/22 was 5.7 per cent, the highest rate reported in ten years.

45. High levels of workforce vacancies in nursing have led to increased expenditure on nursing bank and agency staff. Spending on bank and agency nursing staff increased by 36 per cent in 2021/22 and has increased by 92.9 per cent since 2017 (Exhibit 3). Although expenditure varies widely among boards, total nursing bank and agency spending was £321 million in 2021/22.

Exhibit 3.
NHS workforce data

Headcount
September 2022
180,325
0.6% increase since September 2021
Mar 17 Sep 22


Whole-time equivalent
September 2022
155,913.5
1.0% increase since September 2021
Mar 17 Sep 22


Staff joining
2016/17 2021/22


Staff leaving (turnover rate)
2016/17 2021/22


Vacancy rates
September 2022

Nursing and midwifery
9.0%
Up from 4.5% in March 2017

Allied Health Professionals
8.7%
Up from 3.9% in March 2017

Temporary staffing costs[1]
2021/22

Nursing bank
£232.2m
Up from £142m in 2016/17

Nursing agency
£88.9m
Up from £24.5m in 2016/17

Sickness absence
2021/22
5.7%
Up from 5.2% in 2016/17

Note: 1. Nursing agency and bank staff expenditure figures do not take into account inflation.

Source: NHS Education for Scotland

46. Case study boards' expenditure on nursing agency staff reflect these national trends. In NHS Ayrshire and Arran, nursing agency expenditure increased by 90.8 per cent (from £3.5 million to £6.7 million) in 2021/22. Over the same period, expenditure within NHS Highland increased by 90.5 per cent (from £1.8 million to £3.5 million) and expenditure within NHS Lothian increased by 57.2 per cent (from £4.7 million to £7.4 million).

47. Despite the increases in bank and agency nursing staff working on the frontline, nursing staff are still under pressure. The results of the Royal College of Nursing (RCN) 2022 survey on staffing levels across the UK found that 86 per cent of nurses in Scotland thought that the number of nursing staff in their last shift was not sufficient to meet the needs of patients safely and effectively. Sixty-three per cent of nurses reported feeling exhausted and negative over staffing levels, and 59 per cent reported feeling demoralised. Only 37 per cent reported being able to take the breaks they were supposed to take.[17]

48. The 2022 General Medical Council (GMC) National Training Survey of trainer and trainee doctors found that 37 per cent of Scottish trainees reported feeling burnt out to a very high or high degree because of their workload. Sixty-two per cent of trainees who answered the burnout questions were measured to be at high or moderate risk of burnout. Forty-three per cent reported working beyond their rostered hours daily or weekly.[18]

49. General Practices are under pressure. The British Medical Association (BMA) carried out a survey of General Practices in Scotland in October of 2022, of which 46 per cent of practices responded. Eighty-one per cent of respondents said that demand for GP services was exceeding capacity, and 42 per cent said that demand was substantially exceeding capacity. Thirty-four per cent of practices reported having at least one GP vacancy.[19]

The Scottish Government is continuing to invest in the mental wellbeing of NHS staff, but physical wellbeing remains a concern

50. In our NHS in Scotland 2021 report, we outlined the measures that the Scottish Government was taking to support staff wellbeing. For example, staff now have access to the National Wellbeing Hub, a digital platform that provides a range of self-care and wellbeing resources. The Workforce Specialist service provides confidential mental health assessment and treatment. Work on these continues and we recommend that focus on staff retention and wellbeing is maintained.

51. We also noted that the Scottish Government told us that there is not a culture of seeking help in the health and social care sector. The Scottish Government is taking steps to change this by putting in place wellbeing coaches for staff in managerial roles to encourage their teams to access wellbeing resources. It is also planning to implement its 'Leading to Change' programme to help staff proactively manage culture changes with the aim of retaining more staff.

52. It is unclear how much physical wellbeing provision there is for frontline NHS Scotland staff. The Scottish Government has funded boards to create rest spaces for staff in hospitals. But, because of the high intake of patients, delayed discharges and unscheduled care pressures, rest spaces for staff are often

being used for other purposes. The Scottish Government has made some progress in establishing physical provisions for healthcare staff working in community settings. But there is a further opportunity for it and NHS boards to work together to prioritise creating rest and break facilities and providing hot food and drink for staff in hospitals to prevent staff burn out and improve staff safety and wellbeing.

Progress in tackling the backlog of care has been slow; waiting times and waiting lists continue to grow

53. When Covid-19 struck the UK in March 2020, NHS Scotland was placed on an emergency footing and all non-urgent care was paused. These emergency measures allowed hospitals to focus on caring for people who were seriously ill with Covid-19, but also helped to reduce transmission of the virus within hospitals.

54. Waiting time standards set the maximum amount of time a patient should wait for healthcare. Before the Covid-19 pandemic, NHS boards were already struggling to meet waiting times standards for planned care, and performance has deteriorated further since (Exhibit 4, page 21). Performance during the pandemic will have been influenced by several factors, including clinical prioritisation of patients and the pausing of services at different times.

55. Between 2014 and 2019, waiting lists for planned care were generally increasing year-on-year, although the new outpatient waiting list had begun to level off in 2017. The disruption to health services since the start of the pandemic has caused a much sharper build-up in the number of people waiting. More people are now waiting to be seen at each stage of the referral to treatment pathway than ever before. Planned care waiting lists have continued to grow in the last year (Exhibit 5, page 22).

56. Some specialties, such as ophthalmology and general surgery, have particularly large waiting lists. These two specialties combined account for a quarter of all people waiting for a new outpatient appointment. Nearly half of those on the inpatient/day case waiting list are waiting for an orthopaedic procedure or general surgery.

57. Inevitably, patients are waiting longer for planned care than they were before the pandemic. Most people still waiting for care have been waiting for longer than the national waiting times standards. In some cases, people have been waiting much longer. For example, at the end of September 2022:

- 37,947 (8.0 per cent) had been waiting more than a year for a new outpatient appointment, with 2,114 (0.4 per cent) waiting more than two years.[20]
- 35,337 (24.9 per cent) had been waiting more than a year for inpatient/day case treatment, with 7,612 (5.4 per cent) waiting more than two years.[21]

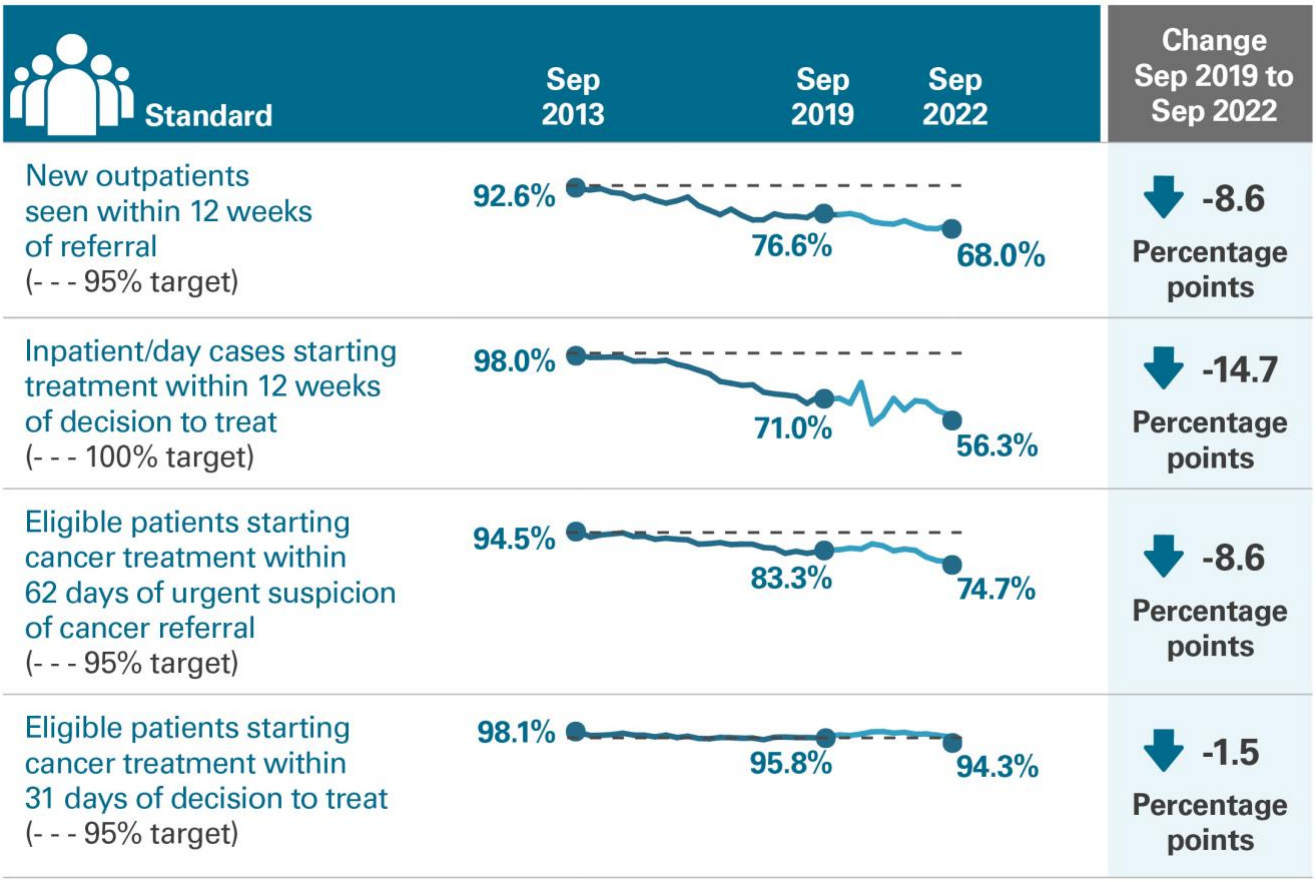
- 5,458 (3.4 per cent) had been waiting more than a year for a diagnostic test or investigation. Most of these people were waiting for an endoscopy.[22]

Before the pandemic it was unusual for people to wait more than a year for planned care.

Exhibit 4.

Performance against planned care and cancer waiting times standards, quarter ending September 2013 to September 2022

Before the Covid-19 pandemic, NHS Scotland was already struggling to meet planned care and cancer waiting times standards, and performance has deteriorated.

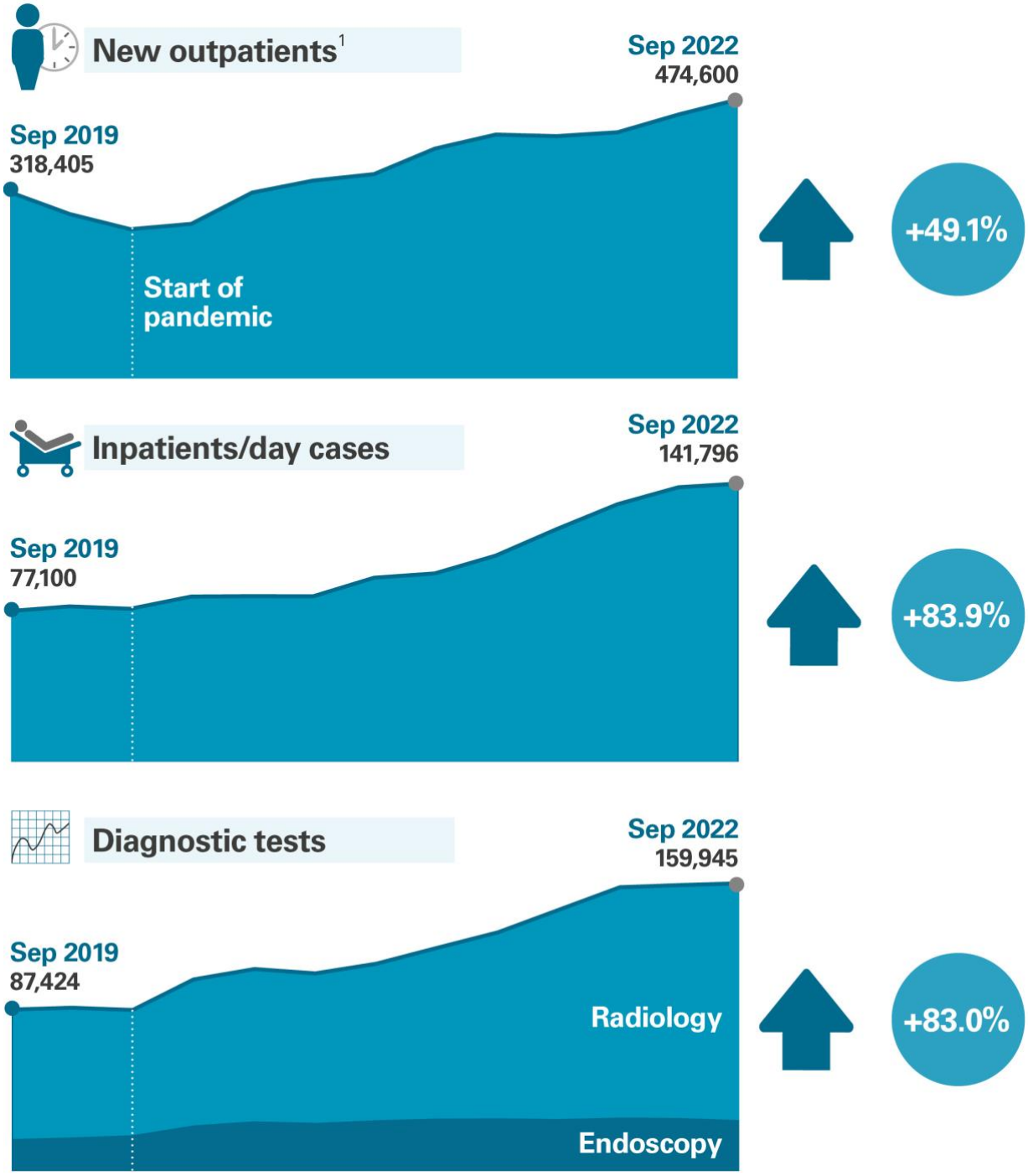


Source: Public Health Scotland

Exhibit 5.

Number of people waiting for planned care, quarter ending September 2019 to September 2022

Waiting lists for planned care within NHS Scotland are larger than ever and continue to grow.



Note: 1. Before October 2019, some patients waiting for a key diagnostic test were included in the new outpatient waiting list. From 1 October 2019, people waiting for these tests were no longer covered by this standard. This largely explains the pre-pandemic decrease in the outpatient waiting list towards the end of 2019.

Source: Public Health Scotland

Waiting times vary among specialties and NHS boards

58. The length of time people are waiting for planned care varies by specialty. It also varies according to the type of appointment required. Among the 20 specialties with the largest outpatient waiting lists, gastroenterology has the highest proportion of patients who have been waiting a long time (more than a year) for an appointment. In the case of inpatient/day case treatment, the specialties with the highest proportions of patients waiting more than a year include paediatric surgery, neurosurgery, ear, nose and throat, urology, orthopaedics, plastic surgery, gynaecology and general surgery. The diagnostic test with the highest proportion of patients waiting more than a year is lower endoscopy.

59. Waiting lists have grown markedly in most NHS boards since the start of the Covid-19 pandemic. However, across and within boards waiting times vary. Our case study boards confirmed that they face different local challenges with specific outpatient specialties and diagnostic services. These mainly relate to local workforce challenges and constraints in physical space. Tackling inpatient/day case waiting lists is made more difficult by several key issues:

- high vacancy rates in key areas (particularly theatre staff)
- pressures associated with unscheduled care activity
- lack of acute care beds due to delayed discharges
- financial constraints
- other issues relating to geography, demographics and the specific health needs of boards' local populations.

Activity is still below pre-pandemic levels and does not meet NHS Recovery Plan targets

60. Waiting list activity is measured by looking at the number of people added to and removed from a list within a certain time frame. People are usually removed because they have attended an appointment or been admitted for treatment. However, removals can occur for other reasons, for example because treatment is no longer required. NHS boards review waiting lists on a regular basis to ensure that patients are removed where appropriate.

61. Waiting list additions and removals, and attendances/admissions fell dramatically when NHS Scotland was placed on an emergency footing in March 2020. Despite some recovery, across NHS Scotland all three measures remain lower than before the pandemic.[23]

62. One of the main objectives of the NHS Scotland Recovery Plan 2021-2026 is to increase planned care activity and capacity beyond pre-pandemic levels. The Scottish Government plans year-on-year increases by opening ten National Treatment Centres (NTCs) and redesigning care pathways. Redesigning care pathways means changing and improving how patients access health services. By the end of 2022/23, it was anticipated that annual activity would increase by 58,000 outpatient appointments and 27,500 inpatient/day case procedures.

Based on data available for the first six months of 2022/23, current activity is running well below NHS Recovery Plan targets (Exhibit 6).

Exhibit 6.

Planned care waiting list activity, 2019 quarterly average versus quarter ending September 2022

Waiting list activity is still below pre-pandemic levels.

New outpatient	2019 quarterly average	Jul - Sep 2022	Difference %
Additions	449,109	414,537	-7.7
Removals	457,532	389,212	-14.9
Attendances	367,294	300,449	-18.2
Inpatient/day case	**2019 quarterly average**	**Jul - Sep 2022**	**Difference %**
Additions	86,514	69,998	-19.1
Removals	85,912	68,213	-20.6
Admissions	70,599	53,474	-24.3

Source: Public Health Scotland

63. Since mid-2020, when NHS Scotland began to remobilise, the number of people being added to waiting lists has often been higher than the number being removed. This is causing waiting lists to continue to grow.

64. Planned surgical activity has not yet returned to pre-pandemic levels. An average of 21,230 planned operations were scheduled within NHS Scotland's theatre systems each month between April and September 2022. This is 23.5 per cent lower than the average number scheduled each month between April and September 2019.[24]

Cancer screening programmes have resumed, and referrals are increasing, but performance against cancer waiting times standards is getting worse

65. At the start of the pandemic, the national cancer screening programmes (Bowel, Breast and Cervical) were paused, and cancer referrals decreased. These programmes have now restarted, and cancer referrals are increasing. Current standards for cancer waiting times are that 95 per cent of all eligible patients should wait no longer than 62 days from an urgent suspicion of cancer referral to start of first treatment, and no longer than 31 days from the decision to treat to start of first treatment. The number of eligible referrals for the 62-day

standard is now higher than pre-pandemic levels, but the number of eligible referrals for the 31-day standard is similar to pre-pandemic levels.

- Between July and September 2022, there were 4,161 eligible referrals for the 62-day standard (6.0 per cent higher than between July and September 2019).

- Between July and September 2022, there were 6,459 eligible referrals for the 31-day standard (1.5 per cent lower than between July and September 2019).[25]

66. Eligible referrals only include patients who are subsequently diagnosed with cancer. They do not include referrals that do not result in a cancer diagnosis. Our case study boards confirmed that the number of patients being referred with an urgent suspicion of cancer (whether eligible or not) had increased noticeably in the last year.

67. Performance against cancer waiting times standards is getting worse (Exhibit 4). Performance against the 62-day standard is lower than ever. For NHS Scotland overall, the 31-day standard was not met in the most recent quarter (July-September 2022) and performance varied across NHS boards.

The number of people dying each year is still higher than average

68. Throughout the pandemic, the number of people dying each year has been higher than average. These are often called “excess deaths”. Many of these deaths are directly linked to Covid-19, but in 2020 and 2021 there were more deaths than usual from some other diseases. These were cancer, heart disease, digestive system diseases and external causes of death (such as drug-related deaths).[26] National data does not show whether these excess deaths are directly related to longer waiting times.

Longer waits are negatively impacting people’s health and wellbeing

69. The Scottish Government has acknowledged that people are waiting too long for treatment.[27] It also recognises the impact of increased waiting times on people’s physical and mental wellbeing.

70. There is some evidence that patients are presenting for care in a worse condition than before the pandemic:

- Evidence given to the Covid-19 Recovery Committee’s inquiry into excess deaths suggests that patients may be presenting for care in a more acute condition than before the pandemic.[28] Some of this evidence relates to the stage at which patients are being diagnosed with cancer. It is acknowledged that determining whether cancer patients are being diagnosed at a later stage of disease is complex. It will be some time before data will be available to answer this question fully. This view was echoed by Cancer Research UK.

- All three case study boards said that patients are presenting for planned care in a frailer condition than before the pandemic. This is particularly

the case for patients who are waiting for orthopaedic procedures, such as joint replacement.

- The Scottish Ambulance Service are finding patients often have more complex needs when they attend calls. They are also receiving a higher number of calls for seriously and critically ill patients.

71. A survey carried out between October and December 2020 by the charity Versus Arthritis highlights some of the negative impacts of waiting for joint replacement surgery.[29] Most survey respondents reported suffering increased levels of pain, reduced mobility and independence, and a deterioration in physical and mental health while waiting for treatment. These findings suggest that people who are waiting for a joint replacement may benefit greatly from additional support while they wait.

Progress has been slow against recovery ambitions

Current pressures threaten to derail the recovery of NHS services, while the backlog of care continues to grow

The Scottish Government's NHS Recovery Plan 2021-2026 is ambitious, and progress has been slow

72. The Scottish Government published its five-year NHS Recovery Plan in August 2021. The plan sets out how the Scottish Government aims to address the substantial backlog in planned care while continuing to meet ongoing urgent health and care needs by increasing activity and redesigning care pathways. The plan committed to increase elective care activity by 10 per cent compared with pre-pandemic levels in outpatient services and by 20 per cent in inpatient and day case services.

73. The Recovery Plan anticipates that most of the increases in outpatient appointments would be driven through NHS boards increasing capacity by redesigning care pathways. For inpatient and day case procedures, NHS boards are expected to deliver an additional 15,500 procedures per year. A network of National Treatment Centres is to provide an additional 40,000 procedures by the end of the plan in 2026.

74. The Scottish Government did not undertake detailed and robust modelling to inform the anticipated increases in activity levels set out in the Recovery Plan. It is currently undertaking an exercise to model capacity across the whole health system over the next ten years. This modelling is intended to integrate demand and capacity for planned and unscheduled care, considering bed capacity and different high-level scenarios.

75. The output from this modelling will help the Scottish Government and NHS boards better understand potential demand for services in the future, considering population demographics and the impact of patients waiting longer for treatment. This should be used to inform and implement service capacity increases at national level and board level that will enable waiting list sizes to decrease and services to be more sustainable in the longer term. It is not clear when this work will be complete, but the Scottish Government should progress it as quickly as possible.

The Scottish Government did not engage fully with NHS boards on the preparation of the Recovery Plan

76. The Scottish Government committed to publishing its NHS Recovery Plan within its first 100 days of office following the Scottish Parliament elections in May 2021. That timescale meant that NHS boards were not involved in setting the ambitions in the plan, despite being responsible for the operational delivery

of the ambitions. The Scottish Government did not ask NHS boards for information on possible increases in activity levels beyond those for National Treatment Centres. The Recovery Plan is a high-level national document and does not fully reflect the variation in challenges and priorities faced by different boards. But our case study boards found that the Recovery Plan gave them renewed focus on working to stabilise and recover services following the pandemic.

77. In April 2022, the Scottish Government asked NHS boards to produce Annual Delivery Plans (ADPs) to help plan their recovery. It asked boards to focus on five priorities. These priorities are:

- Recruitment, retention and wellbeing of the health and social care workforce
- Recovering and protecting planned care
- Urgent and unscheduled care
- Supporting and improving social care
- Sustainability and value.

Our case study boards have aligned their ADPs with their corporate strategies, national priorities and local need. NHS Highland extended the scope of its ADP beyond the five priorities given by the Scottish Government to reflect the need to plan recovery across the whole health and care system.

78. Recovery planning at both national and board level has been shaped by the Scottish Government. Our case study boards would like more autonomy to develop delivery plans based on their own priorities and within their resource constraints. The Scottish Government and NHS boards should develop an agreed approach to recovery planning that reflects both national and local priorities.

The Scottish Government has allocated over £1.2 billion of funding to deliver against its recovery ambitions

79. The NHS Recovery Plan outlines a commitment of £1.26 billion of targeted investment over the next five years (Exhibit 7, page 29). Since the publication of the plan, the Scottish Government has increased its investment in multi-disciplinary teams (MDTs) working with GPs from £150 million in 2021/22 to a recurring £170 million. It has also invested an additional £50 million to help boards redesign pathways for urgent and unscheduled care.

Exhibit 7.
The NHS Scotland Recovery Plan financial commitments

Area of spend	Committed funding £ million
Primary care	172.5
Diagnostics	29.0
NHS Near Me	17.0
NHS 24	20.0
Cancer	174.5
Drug deaths	250.0
Staff wellbeing	40.0
Mental health	120.0
Scottish Ambulance Service	20.0
National Treatment Centres	400.0
Other	24.8
Total	**1.26 billion**

Source: NHS Scotland Recovery Plan 2021-2026

Boards are struggling financially to recover services and tackle the backlog of care

80. There is a tension between the service delivery targets of the NHS Recovery Plan and the finances available to boards to meet them. Boards are entering the financial year with large deficits. They are struggling to align service delivery targets with the costs of tackling the backlog of care, of dealing with increased numbers of unscheduled and urgent care patients, and of hiring agency staff to cover for vacant posts, all alongside continuing Covid-19 costs.

81. Territorial NHS boards submitted estimates to the Scottish Government of the funding needed to reduce waiting times and the backlog of planned care. Two of our three case study boards reported that the funding received from the Scottish Government falls short of what is needed in 2022/23 (Exhibit 8, page 30). NHS Lothian initially reported a shortfall of £5.3 million but has since been given confirmation that it will receive an additional £5.4 million from the Scottish Government. Although these shortfall figures are small relative to overall board funding, the situation highlights the competing financial pressures boards face

and the risk to recovery investment. Boards now face difficult choices to recover services without worsening their underlying deficit.

Exhibit 8.
Estimated shortfall in funding to reduce waiting times in 2022/23 in case study boards

Board	Estimated funding required £ million	Funding allocated by Scottish Government £ million	Shortfall £ million
NHS Ayrshire and Arran	13.0	7.8	5.2
NHS Highland	12.5	8.3	4.2
NHS Lothian	16.6	16.7	n/a

Source: NHS Ayrshire and Arran, NHS Highland, NHS Lothian

Reporting on progress against the Recovery Plan is unclear

82. The Scottish Government published its first NHS Recovery Plan: annual progress update in October 2022.[30] It recognises there was a need to pause work towards some of the recovery ambitions during the first year of the Recovery Plan due to the impact of the Omicron Covid-19 variant. But the progress update states that there has been significant progress in delivering on the ambitions of the Recovery Plan.

83. The progress update does not fully refer to the specific ambitions of the Recovery Plan and the level of progress is not always clear. The Recovery Plan did not include an action plan with detailed timescales and milestones, although there are some high-level timescales and milestones for some ambitions. Without a detailed action plan, it will be difficult to accurately measure progress.

84. The Recovery Plan ambitions are not clearly tracked and progress against key aims of increasing outpatient, diagnostic, and inpatient and day case activity is missing from the update. The Scottish Government stated in the Recovery Plan that the first milestones for those activity increases would be in 2023, and little progress was to be expected in year one of the plan. Appendix 3 shows ambitions to be delivered within the first year of the Recovery Plan and other key ambitions, whether they are reported on within the progress update, and what progress has been delivered against them.

85. The Scottish Government engaged with NHS boards on the Recovery Plan progress update report, but the update does not fully reflect how challenging it has been for NHS boards to recover. Our case study boards have highlighted a mismatch between the progress towards recovery described in the progress update and the recovery progress they have been able to make.

86. The Scottish Government should make sure annual progress updates clearly show what progress has or has not been achieved. It should revisit its recovery ambitions annually to ensure they remain relevant and achievable. It should be clear on any changes it makes.

Delays to the National Treatment Centre programme mean targets for increased activity are unlikely to be met

87. The NTC programme is key to the ambition to increase planned care activity. NTCs are to deliver 72 per cent of the increases in procedures by 2025/26 and were expected to deliver an additional 12,000 procedures by March 2023. The three NTCs that were due to open in 2022, in NHS Fife, NHS Forth Valley and NHS Highland, have been delayed and are now expected to open across the first half of 2023. Phase two of the Golden Jubilee University National Hospital expansion is expected to be complete in late summer 2023.

88. The Recovery Plan annual progress update states that timescales for the remaining NTCs are yet to be defined. Any further delays to the completion of the NTC programme will make it difficult to reach the target of 55,500 additional inpatient and day case procedures by 2025/26. Some NTCs are unlikely to open until late 2027 or early 2028.

89. There are national shortages of staff to fill some of the key roles needed for the delivery of inpatient and day case services, including theatre nursing staff and anaesthetic staff. The Scottish Government is helping NHS boards to recruit staff for NTCs internationally. It is also helping boards explore ways to upskill and redeploy staff into new roles to address gaps. If NTCs are not fully and sustainably staffed, there is a risk that the increases in activity set out in the Recovery Plan will not be fully achieved.

90. The NTCs are a national resource and will be hosted by NHS boards and treat patients from across Scotland, largely on a regional basis. In line with new targets to reduce long waits for treatment, NTC capacity for 2023/24 has been allocated on a regional basis to patients facing long waits for inpatient and day case procedures.

91. The variation between boards in the number of patients experiencing long waits means that host boards may receive a smaller allocation of their NTC capacity than they initially expected as they must prioritise long waiting patients from neighbouring board areas. The Scottish Government has developed a financial charging model. This outlines how boards will pay for the treatment of patients from their area when treated in a NTC located in another board area. This means host boards do not pay for the treatment of patients from other areas.

92. The Scottish Government has said that the approach to allocating NTC capacity will be monitored and adapted over time. It should develop a clear policy to ensure equitable access to NTC capacity across NHS boards beyond 2023/24.

There is a new focus on addressing longer waits

93. The Scottish Government introduced a new Framework for Clinical Prioritisation in November 2020.[31] The framework outlined how NHS boards should prioritise care for patients on planned care waiting lists. It advised that patients with the most urgent clinical need should be seen first.

94. The framework helped NHS boards to prioritise the use of limited staff and theatre capacity when emergency Covid-19 measures were in place. But the focus on urgent cases resulted in many patients, with less urgent clinical needs, waiting longer to be seen.[32]

95. By mid-2022, the Scottish Government and NHS boards realised that the approach to prioritising patient care needed to change. Recognising the impact of long waiting times on patients' health and wellbeing, the Scottish Government stepped-down the Framework for Clinical Prioritisation in July 2022. Instead, the Scottish Government gave NHS boards the flexibility to prioritise long-waiting patients, as well as patients with cancer and those who need clinical care most urgently.

96. On 6 July 2022, the Scottish Government announced new national planned care targets to eradicate long waits for new outpatients and inpatient/day cases in most specialties (Exhibit 9).[33]

Exhibit 9.
Planned Care Targets
New national targets to tackle long waits for planned care were announced in July 2022.

Length of wait to be eradicated	New outpatient target date	Inpatient/day case target date
Over two years	31 Aug 2022	30 Sep 2022
Over 18 months	31 Dec 2022	30 Sep 2023
Over one year	31 Mar 2023	30 Sep 2024

Source: Scottish Government

97. The new targets, although challenging, have given NHS boards a renewed focus for tackling the backlog in planned healthcare. But eradicating waits of over 18 months, and then a year, will be particularly challenging. The severe winter pressures NHS boards experienced in late 2022 and early 2023 will undoubtedly have some impact on their ability to meet these targets, although the full impact is not yet understood.

The wording of the new planned care targets is open to interpretation

98. The new targets are aimed at eradicating long waits in most specialties. But the number of people waiting for treatment varies significantly among specialties. In the case of low-volume specialties, long waits can be eradicated by treating a small number of people. In the case of other higher-volume specialties, clearing waiting lists would require many more people to be treated.

99. The wording of the new targets is open to interpretation. No specific information was given to the public about what was meant by “most specialties”. It may not be clear to long waiting patients that they may not be seen by a target date, particularly if waiting for an appointment or procedure in a high-volume specialty.

100. In practice, NHS boards have focused on reducing the number of people facing long waits across all specialties, alongside treating patients with cancer and those who need urgent clinical care.

101. The Scottish Government should ensure that the wording of any future waiting times targets is clear and lends to consistent and accurate reporting of progress in high- and low-volume specialties.

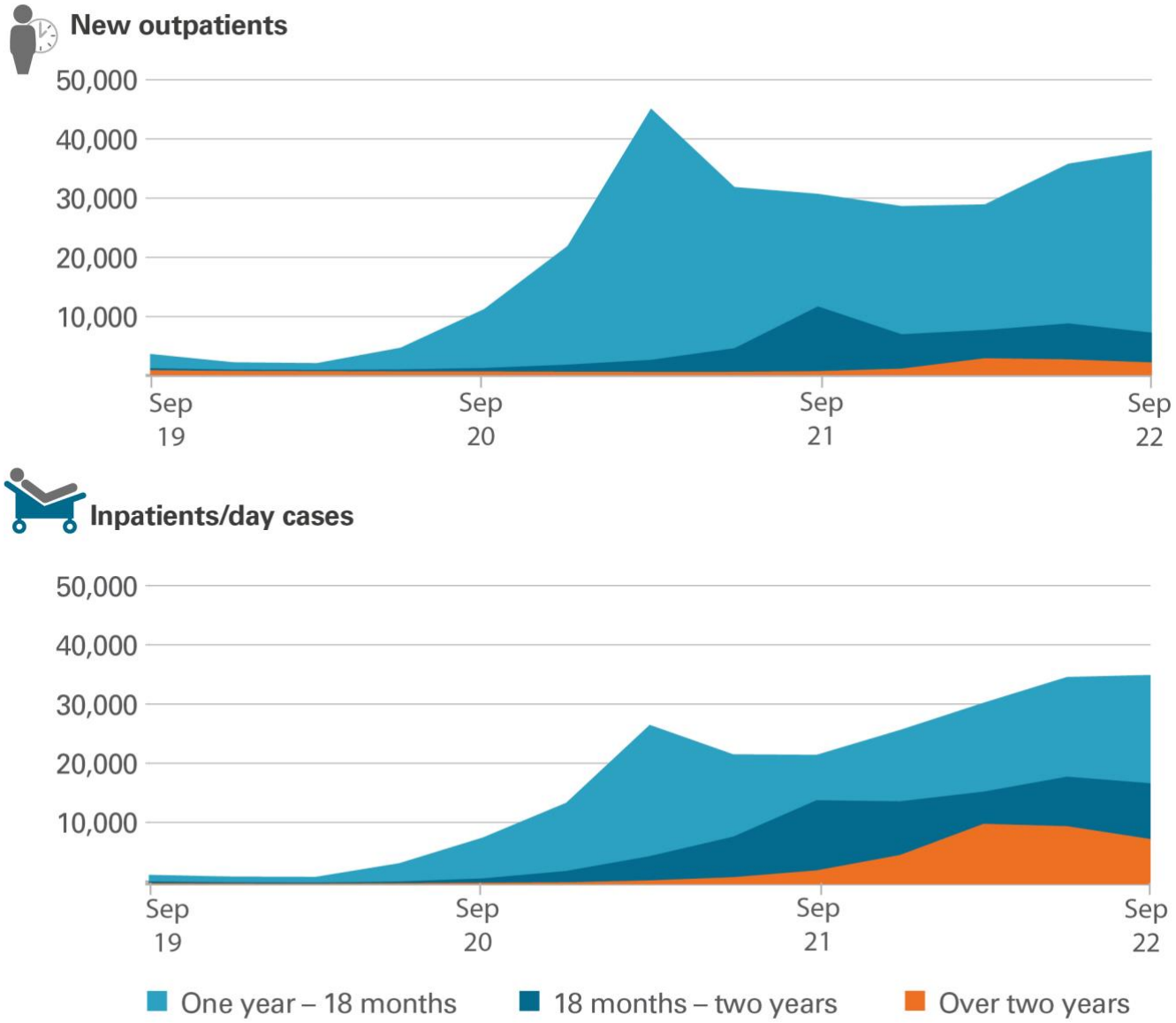
Some progress has been made in reducing long waits

102. The most recent waiting times information shows some progress in reducing waits of over two years for planned care (Exhibit 10, page 34). Despite this progress, the Scottish Government acknowledges that, in the case of some specialties, waits are still too long.[34]

Exhibit 10.

Number of people on planned care waiting lists who have been waiting for more than a year, quarter ending September 2019 to September 2022

There has been some progress towards reducing the number of people waiting for more than two years.



Source: Public Health Scotland

Patients have not always been given clear information about how long they may need to wait for planned care

103. The Scottish Government has taken steps to ensure that patients have access to information about typical waiting times. In August 2022, the Scottish Government, in collaboration with Public Health Scotland and NHS 24, launched an online waiting times platform aimed at the public.[35] For each board

and specialty, the platform shows the median waiting time experienced by patients who were treated and came off the waiting list in the last calendar quarter. The median waiting time is the time in which half of the patients were seen; the remaining half will have waited longer.

104. The information on the new waiting times platform was not universally welcomed. Case study boards expressed strong concerns about the use of the median waiting time for patients who had been treated. Boards told us that this information, given in isolation, does not give people an accurate indication of waiting times. An official concern about the platform was raised with the Office for Statistics Regulation (OSR) by a member of the public and an MSP.

105. Responding to the concerns raised, the OSR concluded that information on the platform could potentially mislead some patients about the length of time they may have to wait.[36] For example, in some specialties, those with non-urgent clinical needs may experience a much longer wait than suggested by the figures. The Scottish Government and Public Health Scotland have confirmed they are taking steps to address these concerns and the platform will be reviewed and revised if necessary.[37]

106. The Scottish Government should ensure that all future communication on expected waiting times gives clear and meaningful information about how long people can expect to wait for treatment.

There has been progress against some recruitment targets, but workforce remains the biggest risk to recovery

Significant recruitment targets were set out in the Recovery Plan that add to existing commitments

107. The recruitment targets in the NHS Recovery Plan cover both existing and new targets. The Scottish Government has made progress towards achieving some of these targets, but other key targets have not been met or remain at risk (Exhibit 11, page 36). The Scottish Government needs to provide evidence that achieved targets, such as the increased number of multi-disciplinary teams providing support to GPs, and additional mental health workers in the community, are having an impact on service delivery and efficiency.

108. One key target that is not on track is the Scottish Government's plans to increase the GP workforce by 800 (headcount) by 2027. In our 2019 report, NHS Workforce Planning – Part 2, we provided modelling that showed that this target would be challenging to achieve. This remains a risk to the recovery of primary care. Since 2017, excluding GP trainees, the GP workforce has increased by 113 (headcount).[38] Public Health Scotland estimates that GP WTE decreased by 26.4 between 2017 and 2022.[39]

Exhibit 11.

Key recruitment targets made in the NHS Recovery Plan, and their progress to date

Some recruitment targets are on track or have been achieved, but other key targets have not been achieved or are at risk.

Key recruitment target	Progress	Status
1,000 additional mental health staff in primary care	Recruitment began in early 2022, but planned funding for primary care has been cut by £65 million, and mental health by £38 million, to fund proposed pay deals for NHS staff.[1]	At risk
1,500 new NTC staff	Management information indicates that by November 2022 around 30 per cent of the 1500 staff have been recruited. The Scottish Government has undertaken to publish workforce statistics on NTC recruitment in 2023.	On track
Providing general practices with more support from MDTs in the community to support the new General Medical Services contract	Although there is no specific target for this commitment, the number of healthcare professionals providing service to GPs has increased by 3220.1 WTE since 2018.[2]	Progress made
Increasing the GP workforce by 800 (headcount) by 2027/28	Between 2017 and 2022, GP numbers (excluding performer registrar GPs/trainees) increased by only 113 (headcount).[3]	Not on track
800 additional mental health workers in A&E, general practices, and police custody suites by 2022	At 1 April 2022, an additional 958.9 WTE mental health posts had been filled.[4]	Target achieved
Training 500 additional advanced nurse practitioners (ANPs) by 2021	According to monitoring and evaluation information from NHS Education for Scotland, 536 ANP trainees had completed as of August 2021.[5] However, between September 2017 and September 2022, the overall ANP workforce increased by only 319 (headcount).[6]	Target achieved

Notes:
1. Emergency Budget Review 2022-23, Scottish Government, November 2022.
2. Primary Care Improvement Plans, Summary of Implementation Progress at March 2022, Scottish Government, June 2022.
3. General Practice: GP Workforce and Practice List Sizes 2012-22, Public Health Scotland, December 2022.
4. Mental Health Workers: Quarterly Performance Reports, Scottish Government, July 2022.
5. Report to Chief Nursing Officer Directorate, NHS Education for Scotland, August 2021.

6. Advanced Nursing Practice census data covering March 2016 to September 2022, NHS Education for Scotland.

Source: Public Health Scotland, NHS Education for Scotland, and Scottish Government

The Scottish Government plans to increase undergraduate medical and nursing places to meet future healthcare demand

109. A key part of the Scottish Government's National Workforce Strategy for Health and Social Care is increasing undergraduate medical and nursing places. It increased funded places for nursing and midwifery in 2022/23 by over 8 per cent to 4,837 places. It is also set to increase the number of undergraduate medical school places by 500 by the end of this parliament. However, both the Scottish Government and NHS boards have expressed concern around take up and attrition rates for nursing places. Data from the University and Colleges Admissions Service (UCAS) and from the Scottish Government from the end of the 2022 cycle shows that 4,367 out of 4,837 nursing and midwifery places in Scotland have been filled, leaving 470 places unfilled.[40]

110. There are concerns around medical supervision capacity for trainees. NHS Education for Scotland (NES) is working to increase capacity for supervision in GP practices because there are currently not enough practices approved to accommodate planned increases in trainees. A lack of supervision capacity within secondary care settings affects several different types and levels of trainees. NHS boards are recruiting internationally to fill short-term workforce gaps in medical posts. However, this will not address the medical supervision issue in the short-term and may actually place additional demands on medical supervision.

111. The National Workforce Strategy for Health and Social Care sets out a plan to mitigate the domestic supply shortfall in medicine and nursing over the next four to five years through international recruitment. This will be the Scottish Government strategy in the short- to medium- term until domestic training numbers are more sustainable. It is providing a recurring £1 million to support each board to help identify international staff who can complete training within three months of coming into the UK.

112. It costs around £12,000 to recruit an international nurse, and £10,000 for an AHP. Boards have expressed concerns over their ability to cover all the costs required to meet international recruitment targets, and over the value for money that international recruitment offers as a means to increase the registered workforce. The Scottish Government has met the up-front recruitment costs in full for the international recruitment targets announced in 2021 and 2022. But it argues that it achieves value for money as it does not pay for the undergraduate training costs for these staff.

113. NHS Ayrshire and Arran has been successful with international recruitment and in 2022/23 plans to recruit 43 nurses and ten radiographers from outside the UK. NHS Lothian is due to recruit 40 international nurses in 2022/23. NHS Highland found the process time-consuming and expensive, and the lack of affordable housing in the region made it challenging to implement.

114. As well as providing additional funding for boards, the Scottish Government has set up the Centre for Workforce Supply to advise boards on effective international recruitment models. It has also commissioned NES to develop and deliver preparation and training resources for their Objective Structured Clinical Examination (OSCE).

The Scottish Government and NHS boards must continue to focus on staff retention and workforce productivity as well as recruitment

115. The National Workforce Strategy for Health and Social Care outlines the 'Five Pillars of the Workforce Journey' to understand and build the health and social care workforce. The five pillars are: Plan, Attract, Train, Employ, and Nurture.

116. Measures to retain existing staff mentioned in the NHS Recovery Plan include: a four per cent, on average, pay rise in May 2021 for NHS Agenda for Change staff; NHS Scotland continuing to maintain competitive terms and conditions of service; and continued support for staff wellbeing through the National Wellbeing Hub and Helpline.[41] In November 2022 the Scottish Government made a further pay increase offer of, on average, 7.5 per cent for NHS Agenda for Change staff (paragraph 20).

117. Further measures have been taken to retain staff. The Scottish Government has implemented a 'retire and return' programme, that allows recently retired doctors and nurses to return to the NHS to work on a more flexible basis. It has also devolved powers to NHS boards to help returning staff with pension taxation issues.

118. Our case study boards are successfully implementing a range of measures to improve workforce productivity and recruitment. NHS Ayrshire and Arran is working to redeploy staff hired on temporary contracts during the pandemic into vacant permanent posts and has made a capital investment in three staff wellbeing hubs at hospital sites. NHS Highland is consulting medical staff to determine if more use can be made of physician assistants and is exploring the possibility of creating a band 4 nursing associate role to take on some of the work currently carried out by doctors and nurses. NHS Lothian is assessing a redesign proposal that aims to improve the way in which MDTs work in wards and is also making it easier for band 2 and band 4 staff to take up vacant positions.

119. In our NHS in Scotland 2021 report we recommended that the Scottish Government and NHS boards improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need. We have seen little evidence of progress with this, and this recommendation remains relevant to project future need and monitor staff retention measures.

The Scottish Government and NHS boards must maintain momentum in embracing innovation

120. In our NHS in Scotland 2021 report we called for the Scottish Government to build on the innovation seen during the Covid-19 pandemic to continue to reform services.

There are early signs of progress to drive forward innovation

121. The Scottish Government has arrangements in place to scale up and roll out innovation. In 2021, the Scottish Government commissioned NHS Golden Jubilee to establish the national Centre for Sustainable Delivery (CfSD). The role of the CfSD is to help Scotland's healthcare system recover through sustainable technological innovation, digital solutions, and the redesign of care pathways. The CfSD is also responsible for the overall governance and coordination of the Accelerated National Innovation Adoption (ANIA) Pathway. The ANIA Pathway allows tested innovations to be assessed for national rollout.

122. This pathway has contributed to the increased use of cytosponge, which is a new method of detecting oesophageal cancer, and to colon capsule endoscopy, a capsule with small cameras that provides a less invasive alternative to a colonoscopy. While there are currently a number of digital innovations being assessed through this pathway, including digital dermatology and theatre scheduling, it is still too early to tell how effective the ANIA pathway will be for transforming services at scale in a sustainable way.

123. The CfSD is working on several programmes designed to increase capacity in primary and secondary care. Examples include:

- Remote consulting, a pathway to support virtual appointments
- Active Clinical Referral Triage (ACRT), a pathway to help senior clinical decision-makers to refer patients to the most appropriate care by reviewing all relevant electronic patient records
- Discharge Patient Initiated Reviews, a pathway that enables patients to request routine follow-up appointments if they feel this is necessary, thus eliminating unnecessary appointments
- Accelerating the Development of Enhanced Practitioners (ADEPt), an initiative to facilitate the sharing and spread at pace of innovative workforce roles that add capacity to teams and services.

124. The Scottish Government is also investing in redesigned care pathways and new ways of working that move care closer to home. Since 2020, it has invested £8.1 million in the Hospital at Home programme. Its additional investment of £50 million for the Urgent and Unscheduled Care Collaborative has supported the Outpatient Parenteral Antimicrobial Treatment (OPAT) scheme and Respiratory Community Response Teams. Together, these programmes have created capacity for over 600 virtual beds. The OPAT programme treats an average of 250 people per week and has saved over 45,000 hospital bed days so far in 2022.

125. All our case study boards have benefitted from working with the CfSD to implement new ways of working. But generally, progress has been slow and varies across boards. Workforce shortages and a rise in urgent and unscheduled care demand have held back progress. To help maintain momentum in embracing innovations, the Scottish Government should work with boards to prioritise key innovations that are locally achievable. It must monitor their effectiveness and value for money once adopted.

Digital access to services is improving, but must not become the only option

126. The Scottish Government and COSLA published their Care in the Digital Age: Delivery Plan 2022-23 in November of 2022. This plan sets out a series of digital innovations and dates of delivery. This includes the increased use of digital therapies in mental health, digital prescribing in hospitals and the development of a 'digital front door' for health and social care services in Scotland. The Scottish Government also launched the National Digital Platform, a cloud-based service that has the aim of helping to integrate digital health and social care services across Scotland.

127. The digital ambitions in this delivery plan have the potential to contribute to more sustainable, efficient and cost-effective ways for people to access healthcare. These ambitions must be balanced against the Scottish Government and COSLA's Digital Health and Care Strategy (2021), which aims to tackle digital exclusion and states that people will not be forced to use a digital service if it is not right for them.[42]

128. The Scottish Government's extension of the Near Me video consulting programme into 55 community hubs, including libraries and community health and care facilities, is an example of good practice in addressing digital exclusion. However, accessing NHS services by telephone and in person should remain as an option for those who prefer this. As digital innovations are scaled up across different services, the Scottish Government should provide evidence that they are being used effectively by the right services, for the right people.

A whole system approach to improving public health is essential

129. It is vital that the Scottish Government works now to lay the groundwork for a more sustainable future. It is important not only to reform how services are delivered, but also to reduce the demand for health services by improving public health.

130. Improving public health is not the sole responsibility of the health and social care sector. In November 2022 the Fraser of Allander Institute published a report entitled Health Inequalities in Scotland.[43] It highlighted that socioeconomic factors, such as income, housing and education, are significant drivers of health inequalities. In our NHS in Scotland 2021 report we recommended that the Scottish Government take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector.

131. It is vital that the Scottish Government facilitates cross-sector working, across its own directorates and with other partners and stakeholders, to tackle the numerous factors contributing to poor public health. There is a need for long-term policy and investment to improve public health and reduce health inequalities.

132. We recommended in our NHS in Scotland 2021 report that the Scottish Government and NHS boards prioritise the prevention and early intervention

agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future. There are signs of early progress with this through the Scottish Government's Care and Wellbeing Portfolio, which aims to coordinate work on improving public health outcomes and reducing health inequalities.

133. The Scottish Government intends this to be a cohesive portfolio of activity rather than a set of separate projects. Progress has been made in laying the groundwork for change. Governance arrangements are now in place to oversee the portfolio, including the establishment of a portfolio Board. The Scottish Government expects to be able to evidence early progress in the next six to 12 months.

134. The Scottish Government has set out its mission and objectives for the Care and Wellbeing Portfolio, as well as its intended outcomes and alignment with Scottish Government priorities. We reported last year that the portfolio is made up of four programmes: Place and Wellbeing; Preventative and Proactive Care; Integrated Planned Care; and Integrated Urgent and Unscheduled Care. The latter two have now been stood down with work on those areas continuing on a business-as-usual basis. A wider NHS Reform programme will take their place in the portfolio.

135. The enablers set out in Exhibit 12 (page 42) show the different functions the Scottish Government is focusing on to progress the Care and Wellbeing Portfolio mission. These show a recognition of the key areas of the health and social care sector that need to be aligned to achieve progress, such as workforce, finances, engagement, innovation, and digital and data.

Exhibit 12.
Care and Wellbeing Portfolio mission and objectives

Portfolio

Our mission to **improve Healthy Life Expectancy** and **achieve fairer outcomes** is underpinned by **3 key portfolio objectives.**

Improve population health and reduce health inequalities

Coherence | **Sustainability** | **Improved outcomes**

Portfolio outcomes

The mission is achieved by taking a **person-centred approach** to delivering **clear outcomes** spanning the short, medium and long-term.

1. Everyone in Scotland gets the **right care, at the right time, in the right place** based on their individual circumstances and needs.

2. **Prevention, early intervention, proactive care and good disease management** keeps people in Scotland healthy, active and independent.

3. **Communities, third sector and public sector work together** to improve health and wellbeing and reduce health inequalities in local communities.

Scottish Government priorities

Many of the influences on health outcomes lie out with health and social care. The cross portfolio priorities **align with the Scottish Government's priorities** and enable us to maximise our reach and impact.

Portfolio programmes & enabling functions

Together the Care and Wellbeing programmes and enablers provide a comprehensive and **progressive health and social care reform package.**

Place & wellbeing | **Preventative & proactive care** | **NHS reform**

Enablers
(Digital & data; innovation; workforce; sustainability & value; co-design; quality improvement; analytics & evidence)

Source: Scottish Government

The Scottish Government must be clear on what progress is being made in reforming health and care services and what can realistically be achieved

136. It remains to be seen whether reform can happen at the scale and pace needed. It is vital that measures are in place to monitor the impact of innovation and redesign and provide clarity on the effectiveness, efficiency and value for money of new ways of delivering services.

137. The Scottish Government and NHS boards must make sure health services can be delivered in a sustainable way. They must be clear on what resources are available and what can be delivered within financial and operational constraints. When driving forward innovation and redesign they should be clear on what success would look like and what timescales they are working to. That must be informed by reliable modelling and data.

138. Crucially, the Scottish Government and NHS boards must also monitor public awareness and acceptance of new ways of accessing services to ensure their effectiveness. In our NHS in Scotland 2021 report we recommended that the Scottish Government and NHS boards work with patients on an ongoing basis to inform the priorities for service delivery and be clear on how services are developed around patients' needs. There is little evidence of this in the past year.

139. The Scottish Government and NHS boards must have an open conversation with the public about the challenges facing the NHS and what they mean for future service delivery. It should make clear to the public what can realistically be achieved and involve them in the difficult choices that may have to be made.

Appendix 1

Audit methodology

This is our annual report on the NHS in Scotland. The report focuses on the Scottish Government's NHS Recovery Plan 2021-2026. It covers:

- the challenges facing the Scottish Government and NHS boards as they try to recover services following the Covid-19 pandemic
- the scale of the backlog of care that built up during the Covid-19 pandemic
- the development of the NHS Recovery Plan
- progress against the NHS Recovery Plan ambitions, including workforce ambitions
- NHS reform and new ways of delivering services.

Our findings are based on evidence from sources that include:

- the NHS Recovery Plan and other relevant Scottish Government strategies
- the audited annual accounts and reports on the 2021/22 audits of NHS boards
- activity and performance data published by Public Health Scotland
- publicly available data and information including results from surveys
- Audit Scotland's national performance audits
- interviews with senior officials in the Scottish Government and some NHS boards
- interviews with third-sector organisations.

We also conducted case studies in three territorial NHS Boards to better understand how the NHS Recovery Plan is being implemented and the impact it has on boards. The case study boards are:

- NHS Ayrshire and Arran
- NHS Highland
- NHS Lothian.

Our case studies are based on evidence from sources that include:

- interviews with senior board officials
- NHS board delivery plans, financial plans and workforce plans.

Appendix 2

NHS boards' required savings and predicted deficit in 2022/23

NHS board	Total savings required to break even at start of 2022/23 (£000s)	Predicted deficit at end of 2022/23 (£000s)
NHS Ayrshire and Arran	(45,080)	(26,400)
NHS Borders	(23,723)	(12,223)
NHS Dumfries and Galloway	(32,399)	(19,899)
NHS Fife	(22,100)	(10,400)
NHS Forth Valley	(29,312)	0
NHS Grampian	(25,251)	(19,900)
NHS Greater Glasgow and	(181,500)	(51,500)
NHS Highland	(57,272)	(16,272)
NHS Lanarkshire	(43,209)	(14,868)
NHS Lothian	(45,598)	(28,432)
NHS Orkney	(6,909)	(2,003)
NHS Shetland	(3,096)	0
NHS Tayside	(51,234)	(19,596)
NHS Western Isles	(3,851)	0
NHS National Services	(17,001)	0
Scottish Ambulance Service	(17,400)	0
NHS Education for Scotland	(2,800)	0
NHS 24	(2,852)	(676)
NHS National Waiting Times	(4,510)	0
The State Hospital	(511)	300
Public Health Scotland	(4,470)	0
Healthcare Improvement	(477)	0
Total	**(620,556)**	**(221,870)**

Source: Scottish Government analysis of NHS boards' 2022/23 financial plans

Appendix 3

Progress with Recovery Plan ambitions

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
Implement a National Wellbeing Programme for NHS staff	Autumn 2021	Unclear	In addition to the National Wellbeing Hub and its Workforce Specialist Service (already in place at the time of publication of the Recovery Plan), the following staff services have been implemented: Coaching for Wellbeing, Reflective Practice, and the Workforce Development Programme.	
Recruit 800 new mental health workers	2022	Yes	An additional 958.9 whole time equivalent (WTE) mental health roles have been filled. This was an existing commitment.	
Increase number of GPs by 800	2028	Yes	An additional 277 GPs were recruited between 2017-21. At 30 September 2021 the number of GPs (headcount) was 74 more than in the previous year.	Further analysis on GP recruitment up to 2022 is provided in paragraph 108. Excluding GP trainees, the number of GPs (headcount) increased by only 136 between 2017 and 2021 and by 56 in 2021. The increase of 56 is not

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
				progress in the first year of the Recovery Plan as data is from 2021 not 2022. It is misleading to include GP trainee numbers within progress updates about meeting the target of 800 additional GPs.
Increase number of Advanced Nurses Practitioners (ANPs) by 500	2021	Yes	Completed a number of actions from the Integrated Workforce Plan, including 'exceeding' commitment to deliver an additional 500 Advanced Nurse Practitioners.	Neither the NHS Recovery Plan nor the progress update specifies that this target refers to financially supporting the training of an additional 500 ANPs. Although this training target was met, the additional trained ANPs has not translated into a similar increase in ANP workforce capacity, and so is misleading as a measure of additionality in ANPs. Exhibit 11 provides further detail on the number of ANPs trained and total increase in ANP workforce.
All 925 GP practices to have practice-based (or access to) nursing and pharmacy support	April 2022	Yes	95 per cent of practices have access to some health board delivered pharmacy support. 75 per cent of practices have access to some health board	

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
			delivered nursing support.	
Maximising multi-disciplinary team (MDT) capacity within the community		Yes	Funding for MDTs increased to £170 million this year. Recruited over 3,220 primary care MDT members at end of March 2022.	The funding increase to £170 million was in line with inflation, as had been outlined against the original allocation of £155 million in the Primary Care Improvement Plan. The increase in MDT staff in 2021/22 was 793.2 WTE.
Expansion of Pharmacy First Service and a new Pharmacy Women's Health and Wellbeing Service	Women's Health and Wellbeing Service in first year of Recovery Plan	Yes	Pharmacy First delivered 2.9 million consultations in 2021/22. A new Pharmacy Women's Health Service was introduced.	Pharmacy First had already been implemented at the time of Recovery Plan publication. The progress update does not specify how it has expanded or how much it has increased.
Increase outpatient activity by 10 per cent compared with pre-pandemic levels (140,000 additional appointments). 58,000 additional appointments by end of 2022/23.	2026 March 2023	No	Target not referenced. Over 76 per cent of outpatient specialties had either no, or fewer than 10, patients waiting longer than 2 years for treatment, and the number of new outpatients seen in the quarter ending June 2022 was 7 per cent higher compared to the same quarter in 2021.	Further analysis on the progress on long waiting patients is provided in Exhibit 10. Despite an increase compared to 2021, outpatient activity for the quarter ending September 2022 shows that activity has not returned to pre-pandemic levels (see Exhibit 6).

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
Increase of 90,000 diagnostic procedures. 78,000 additional procedures by end of 2022/23.	2026 March 2023	No	Target not referenced. In 2021/22, six new mobile magnetic resonance imaging (MRI) scanners and five new mobile computerised (CT) scanners will be deployed, and five additional endoscopy rooms will be opened.	It is unclear if these additional resources are in place, as the update states that this was to happen in 2021/22 but the language used implies that this work is ongoing.
Increase inpatient and day case activity by 20 per cent compared with pre-pandemic levels (55,500 additional procedures per year). 27,500 additional procedures by end of 2022/23.	2026 March 2023	No	Target not referenced. There has been 'significant progress' in that the number of scheduled operations in quarter ending June 2022 was 7.8 per cent higher compared with the third quarter of 2021, the quarter in which the Recovery Plan was published.	Despite the fact that the yearly target increases set out in the Recovery Plan relate to financial years, the update report refers to calendar quarters – this may be confusing when tracking progress against the original ambitions. Monthly averages of scheduled operations between April and September 2022 were 23.5 per cent lower than equivalent period in 2019 (see paragraph 64).
Of the 55,500 additional inpatient and day case procedures, 40,000 are to be delivered at NTCs.	2026 March 2023	No	Four NTCs are due to open in 2023. 12,250 procedures are expected to be delivered in 2023/24 (this figure includes some endoscopy activity to be delivered at the Golden Jubilee	No reference to these milestones or the delays to opening. 12,250 procedures are expected to be delivered in 2023/24 - this is a year later than the timescale for delivering the first

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
12,000 additional procedures to be delivered by NTCs by end of 2022/23.			University National Hospital).	milestone of 12,000 additional inpatient and day case procedures through NTCs. Timescales for other NTCs opening are not given but will be defined 'as part of ongoing business case development'.
1,500 new clinical and non-clinical staff to be recruited to NTCs	2026	Yes	Referenced in the steps the Scottish Government are taking, but no measurable progress in numbers so far.	
Redesign of Urgent Care Programme aims to reduce the numbers of people who "self-present" to hospital as a first port of call by 15 to 20 per cent		No	Reduction in self-presentation attendances is not tracked. 10.1 per cent of patients that called NHS 24 111 in July 2022 were referred to Flow Navigation Centres (FNCs). It is also reported that additional virtual capacity pathways, e.g., Outpatient Antimicrobial Therapy (OPAT) have saved 45,000 bed days this year.	Although 10.1 per cent of NHS 24 111 callers in July 2022 were referred to an FNC, the update report does not specify how many of these patients did or did not attend A&E following the FNC, or how quickly, and therefore to what extent FNCs are helping to meet the aim of reducing self-presentations in A&E by 15 to 20 per cent or providing faster access to A&E for those who need it.
Publish a refresh of the Framework for Effective Cancer Management	September 2021	Yes	Published in December 2021.	

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
Meeting the 31- and 62-day cancer standards on a sustainable basis	Over the parliamentary term	Yes	The report states that progress has been made in several areas: Three Rapid Cancer Diagnostic Services (RCDS) have been implemented. Funding has been provided to establish single points of contact for cancer patients and to improve diagnosis and treatment. A National Radiotherapy Plan has been published A Scottish Cancer Network has been established. The Scottish Government is committed to providing an additional £40 million to improve performance and to date this has been invested in additional diagnostic clinics and theatre provision for the most challenged care pathways. The report does not mention the fact that performance against the cancer targets is getting worse. It states only that the median wait for the	The three RCDS were already in operation at the time of the publication of the Recovery Plan. The additional £40 million was already committed in the Recovery Plan and it is unclear how much has been invested in the past year. Reference to median waiting time for only one cancer standard does not reflect the deteriorating performance against these standards.

Recovery Plan Ambition	Timescale	Is the ambition covered in the Progress Update Report?	Reported Progress in the 2022 Recovery Plan Progress Update	Discrepancy
			31-day target is five days and that the number of patients coming through the 62-day pathway has increased by 4 per cent in the most recent quarter compared with the same quarter pre-pandemic.	
Introduce a paramedics students bursary	September 2021	Yes	A bursary was introduced for all students starting eligible courses in September 2021.	
Publish a National Workforce Strategy	End of 2021	Yes	Published in March 2022.	

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NHS in Scotland 2022

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AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 915839 03 9 AGS/2023/1

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**				✓		
Delivery of Annual Workplan 2022/23	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Annual Audit & Risk Committee Workplan 2023/24	**Board Secretary**					✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Review of Code of Corporate Governance	**Board Secretary**	**Deferred to next mtg**	✓				
Annual Assurance Statement 2021/22	**Board Secretary**		✓ Draft	✓			
Annual Assurance Statements from Standing Committees 2021/22	**Board Secretary**		✓				
IJB Annual Assurance Statement 2021/22	**Board Secretary**		**Deferred to next mtg**	✓			
Significant Issues of Wider Interest	**Director of Finance & Strategy**		✓ Final				
Governance Statement	**Director of Finance & Strategy**	✓ Draft	**Deferred to next mtg**	✓			

Governance Matters (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Audit Review of Property Transactions Report 2021/22	**Internal Audit**				✓		
Losses & Special Payments	**Head of Financial Services**		✓		✓	✓	✓
Risk							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Risk Management Report 2021/22	**Risk Manager**	✓ Draft	✓				
Board Assurance Framework (BAF)	**Risk Manager**	✓			✓	**Replaced by Corporate Risk Register**	
Corporate Risk Register	**Director of Finance & Strategy**				✓	✓	✓
Risk Management Key Performance Indicators 2021/22	**Risk Manager**	**Deferred until work on framework concluded**			**Deferred until work on framework concluded**	✓ **Update**	
Risk & Opportunities Group and Progress Report *(Replaces - Risk Management Improvement Programme – Progress Report, from Dec '22)*	**Risk Manager**	✓			✓	✓	✓ **Included in Corporate Risk Register**
Governance – Internal Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Audit Progress Report	**Internal Audit**	✓			✓	✓	✓
Internal Audit Annual Report	**Internal Audit**	**Draft not available due to timings**	✓				
Internal Audit – Follow Up Report on Audit Recommendations 2021/22	**Internal Audit**				✓	✓	✓
Annual Internal Audit Plan 2022/23	**Internal Audit**	✓ Draft	✓				

Governance – Internal Audit (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
FTF Shared Service Agreement / Service Specification	**Internal Audit**					**Deferred to next mtg**	✓ **Part of Internal Audit Framework**
External Quality Assessment (5 yearly)	**Internal Audit**				✓		
Internal Controls Evaluation Report 2022/23	**Internal Audit**					✓	✓ **Final**
Governance – External Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Audit Plan 2022/23 - Azets	**External Audit**					✓ **Strategy**	✓
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**	✓					✓ **Added**
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓	✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓				
Annual Accounts & Financial Statements 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Annual Audit Report (including ISA 260) 2021/22	**External Audit**			✓			
Letter of Representation (ISA 580) 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Patients' Funds Accounts 2021/22	**Head of Financial Services**			✓			

Annual Accounts (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Statement of Assurance to the NHS Board 2021/22	**Board Secretary**			✓			
Counter Fraud							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session			Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	Private Session					
Adhoc							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Private Meeting with Internal / External Auditors	**Committee**				Private Session		✓
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**	**As required**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**						
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓					

Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Audit Framework	**Chief Internal Auditor**	✓ **Deferred from 17/03/22**					✓
Notification of External Audit Appointment from 2022/2023	**Director of Finance & Strategy**	✓					
Partnership Agreement between Health Boards & Counter Fraud – Update	**Head of Financial Services**	Private Session					
Extract from Internal Audit Framework	**Chief Internal Auditor**		✓				
Audit Scotland Technical Bulletin	**Head of Financial Services**				✓ **2022/2**	✓ **2022/3**	✓ **2022/4**
Introduction from Azets External Auditors'	**External Auditors**				✓		
Fife IJB Draft Internal Audit Joint Working and Reporting Protocol	**Chief Internal Auditor**				✓		
Publication of Blueprint for Good Governance, Second Edition	**Board Secretary**						✓
Payroll Service Transfer to NSS Assurance Statement	**Director of Finance & Strategy**						✓
Audit Scotland Annual Overview Report 2022	**Director of Finance & Strategy**						✓
Training Sessions Delivered							
	Lead		**16/06/22**			**11/01/23**	**13/02/23**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**		✓				
Corporate Risk Register	**Director of Finance & Strategy**					✓	
Committee Assurance Principles	**Chief Internal Auditor/Board Secretary**						✓

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 March 2023**
Title:	**Proposed Annual Workplan 2023/2024**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Margo McGurk, Director of Finance & Strategy**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Approval

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Audit & Risk Committee last agreed its annual workplan in March 2022, to manage effectively the work of the Committee throughout the year. The version of the workplan for this year reflects the June 2023 date for the consideration of this year's annual financial statements, as agreed with the External Auditors.

2.2 Background

The Audit & Risk Committee normally sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas. The NHS Fife Code of Corporate Governance states that all Committees "will draw up and approve, before the start of each year, an annual workplan for the Committee's planned work during the forthcoming year".

2.3 Assessment

An updated version of the Audit & Risk Committee workplan is attached for the Committee's consideration. Included therein, are two post-meetings each year (August and March) for members to meet privately with the Internal and External Auditors, without management present.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's financial accounting processes is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in the Committee providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Finance & Strategy and Head of Financial Services and takes account of any initial comments thus received. Input has also been sought from Internal Audit, External Audit and the Risk Manager on the timings and schedule of their particular items.

2.4 Recommendation

The paper is provided for:

Approval – subject to members' comments regarding any amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix 1- Audit & Risk Committee Workplan 2023/2024

Report Contact
Margo McGurk, Director of Finance & Strategy
Email: margo.mcgurk@nhs.scot

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2023 / 2024

Governance - General						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Assurance Statement 2022/23	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2022/23	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2024/25	**Board Secretary**			✓		
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2022/23	**Board Secretary**		✓			
Internal Audit Review of Property Transactions Report 2022/23	**Internal Audit**		✓			
Losses & Special Payments	**Head of Financial Services**		✓	✓	✓	✓
Review of Annual Workplan 2024/25	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Significant Issues of Wider Interest	**Director of Finance & Strategy**	✓ Draft	✓ Final			

Risk						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Risk Management Report 2022/23	**Risk Manager**	✓ Draft	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓		✓	✓	✓
Risk Management Key Performance Indicators 2022/23	**Risk Manager**	✓		✓	✓	✓
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓		✓	✓	✓
Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓		✓	✓	✓
Internal Audit Annual Plan 2023/24	**Internal Audit**	✓ Final	✓			
Internal Audit Annual Report 2022/23	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2022/23	**Internal Audit**	✓		✓	✓	✓
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**				✓	✓

Governance – External Audit (cont.)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**	✓				
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓			
Annual Accounts						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓				
Annual Accounts & Financial Statements 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report (including ISA 260) 2022/23	**External Audit**		✓			
Letter of Representation (ISA 580) 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2022/23	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2022/23	**Board Secretary**		✓			
For Assurance						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ **2023/1**		✓ **2023/2**	✓ **2023/3**	✓ **2023/4**
Delivery of Annual Workplan 2023/24	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Counter Fraud						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	Private Session				

Adhoc						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**					
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
GP/R7 Risk Management Policy	**Director of Finance & Strategy**	✓				
Training Sessions Delivered						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				